

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6501</u>
BIRTH NO. <u>68- 6501</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>DUNCAN, IRA C.</u>		2. DATE AND HOUR OF DEATH <u>June 23, 1968</u> <u>5:15</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>23 Veterans Administration Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3900 Loch Raven Blvd.</u> <u>Baltimore, Maryland 21218</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>14-01</u>		
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1803 Eutaw Place</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-08</u>	9. AGE (In years lost birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Charles Duncan, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lida -unknown- Lydia E. Chester</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 3/12/43 to 5/24/43</u>		16. SOCIAL SECURITY NO. <u>212-03-9689</u>		17. INFORMANT <u>Records</u> ADDRESS <u>3900 Loch Raven Blvd.</u>
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Congestive heart failure</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cardiovascular disease</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Months</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>422.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>October 18,</u> 19 <u>67</u> to <u>June 23,</u> 19 <u>68</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>June 23,</u> 19 <u>68</u> and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(X)</u> view the body after death.				
23A. SIGNATURE <u>Andrew P. Weinfeld M.D.</u>		23B. DATE SIGNED <u>6-23-68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Andrew P. Weinfeld, M. D.</u>		23D. ADDRESS <u>3900 Loch Raven Blvd., Balto., Md. 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/26/1968</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 25 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Eugenia K. Seitz</u>		ADDRESS <u>5209 York Rd. Balto. Md. 21212</u>

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FUNERAL DIRECTOR: IMPORTANT

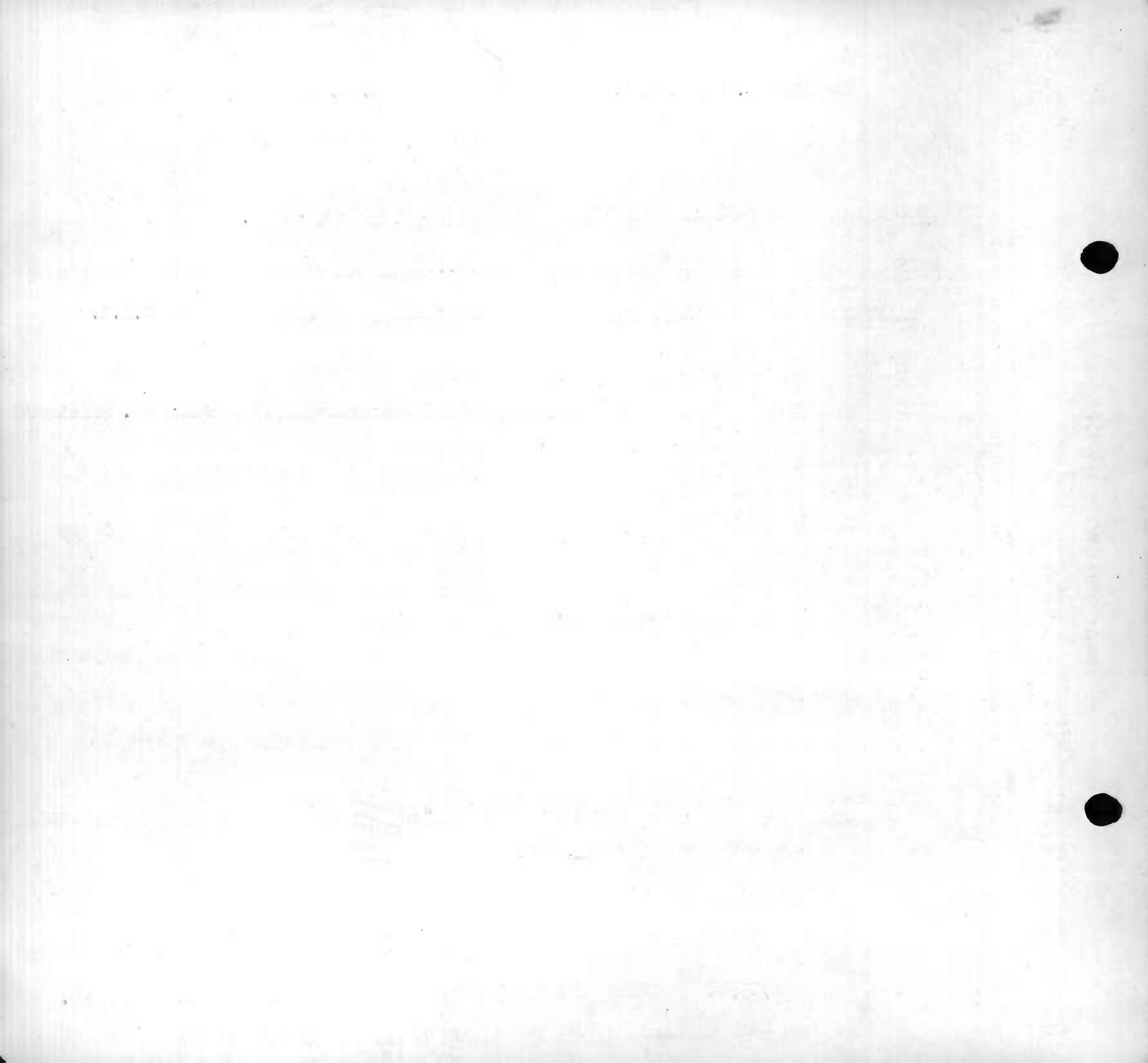
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6502

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLARENCE O. SUNDERLAND		6/22/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL				A. STATE MARYLAND B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				#1618 T7I9 JACKSON ST. 2404	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1/19/97	71	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
PAINTER		SHIP YARD		MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
UNKNOWN				UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WWI		215 01 3066		Roland Sunderland T7I9 Jackson St. Baltimore	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				1d.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				5yr.	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis					
(B) Arteriosclerosis					
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-1-1968 to 6-23-1968, that (I) (we) last saw the deceased alive on 6-21-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A.C. SOLLID				6-24-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
A.C. SOLLID				707 E. FORT AVE. BALTO., MD. 11230	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/25/68		CEDAR HILL CEMETERY	
				GLEN BURNIE MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 25 1968		Robert E. Jenkins		McGilly & Baltimore - Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
68- 6503 **CERTIFICATE OF DEATH** REG. NO. 68- 6503

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLEMENS Mr CHARLES		2. DATE AND HOUR OF DEATH 6/22/1968 11-47-A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-36	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL 35				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1532 EIRINO ST	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/3/1913	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPAIRMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME William Morton Clemens				14. MOTHER'S MAIDEN NAME Anna B. Brewer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Walter Clemens 1532 EIRINO St.	
18. 29710 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Delirium Tremens ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost. Chr Alcoholism Cirrhosis of Liver				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day not known Not known	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/1968 to 6/22/1968 , that (I) (we) last saw the deceased alive on 6/22/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Lim				23B. DATE SIGNED 6-22-68	
23C. PHYSICIAN'S NAME (Type) Rodelio M. Lim				23D. ADDRESS Church Ave & Harp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/24/68		24C. NAME OF CEMETERY or CREMATORY MORELAND MEMORIAL CEM.	
				24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 20 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR B. DABROWSKI 2814 E. Balto. St.	

CHURCH, Walter and Son, Ltd.
1282 LAMAR ST
ALBANY, N.Y.

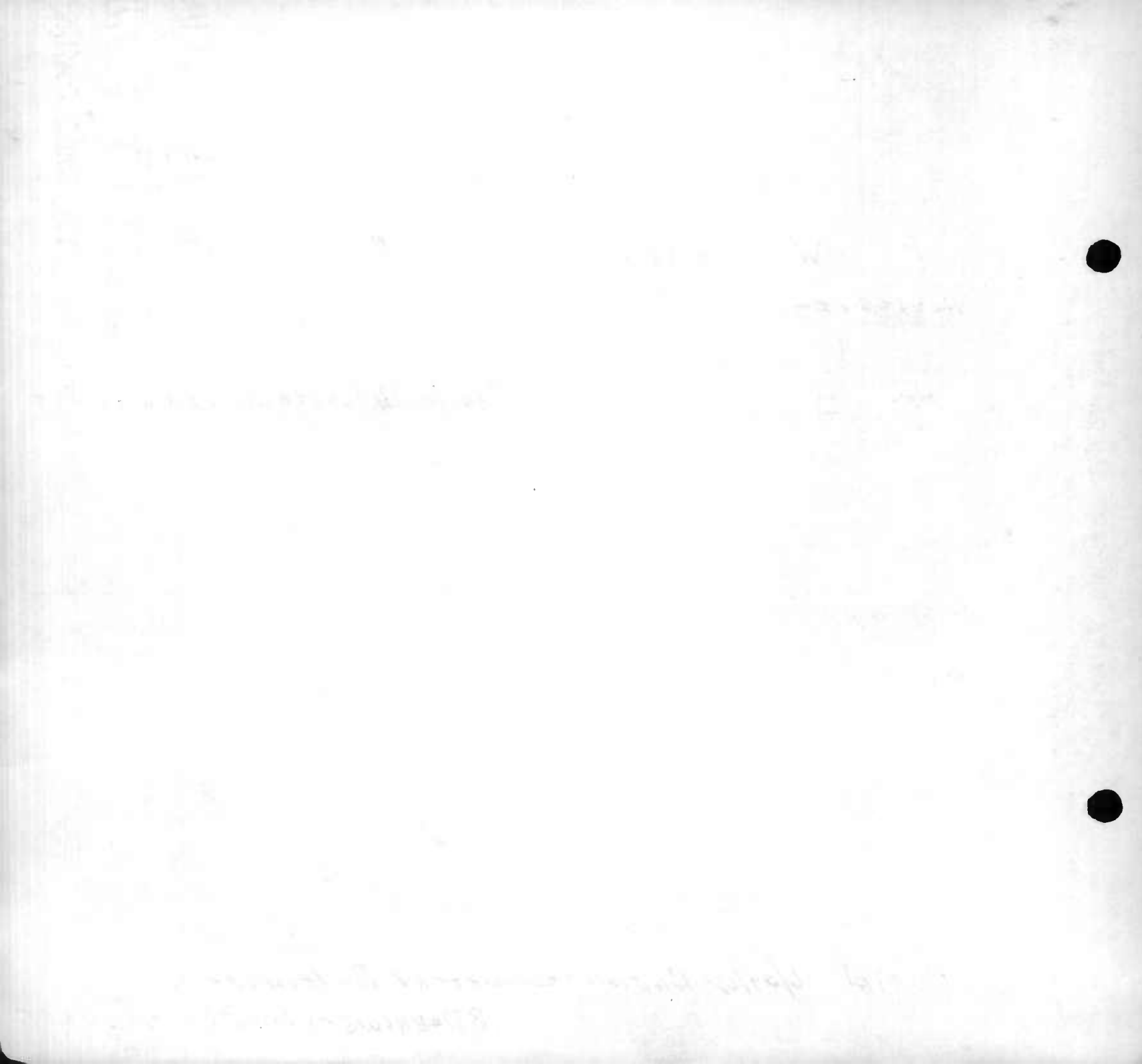
Cto. H. H. H. H. H.
Contract of H. H. H.

6/22/12

FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 68-6504				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-6504	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) LORETA SNYDER				2. DATE AND HOUR OF DEATH 6-21-68 3:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL				A. STATE MARYLAND B. COUNTY			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 211 N. LINWOOD AVENUE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 6-22-87	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME WALLACE JEANETTE			
14. MOTHER'S MAIDEN NAME ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Charles W. Snyder			
				ADDRESS 211 N. Linwood Ave			
18. 412.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 422.1 II							
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-29-68 19 to 6-21-68 19, that (I) (we) last saw the deceased alive on 6-21-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Franki Kananopoulos				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-21-68	
23C. PHYSICIAN'S NAME (Type) ANTHONY A. FELICIANO				23D. ADDRESS FRANKLIN SQ. HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/24/68		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR ALBERT E. S. J.		25C. FUNERAL DIRECTOR B. DABROWSKI		ADDRESS 2818 E. BALTIMORE ST.	



FUNERAL DIRECTOR: IMPORTANT

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68- 6505

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 6505

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGARET FUCHS		2. DATE AND HOUR OF DEATH JUNE-22, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00				A. STATE MD.		B. COUNTY 6-02	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 114 N. BELNORD AVE.				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 114 N. BELNORD AVE.							
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 1, 1896	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME JACOB MERTEL				14. MOTHER'S MAIDEN NAME CATHERINE HERGENROEDER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 21303-7250B		17. INFORMANT ADDRESS MR. CARL SCANDORA 813 MILDRED AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Malignancy of stomach c metastasis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 151X II				Diabetes Mellitus		1 yr.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 15 1968 to June 22 1968 , that (I) (we) lost saw the deceased alive on June 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE I. J. Feinglos M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) I. J. FEINGLOS MD				23D. ADDRESS 2007 E. Pratt St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/25/68		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR John E. Johnson		25C. FUNERAL DIRECTOR B. D. BROGSKI 2814 E. BALTO. ST.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

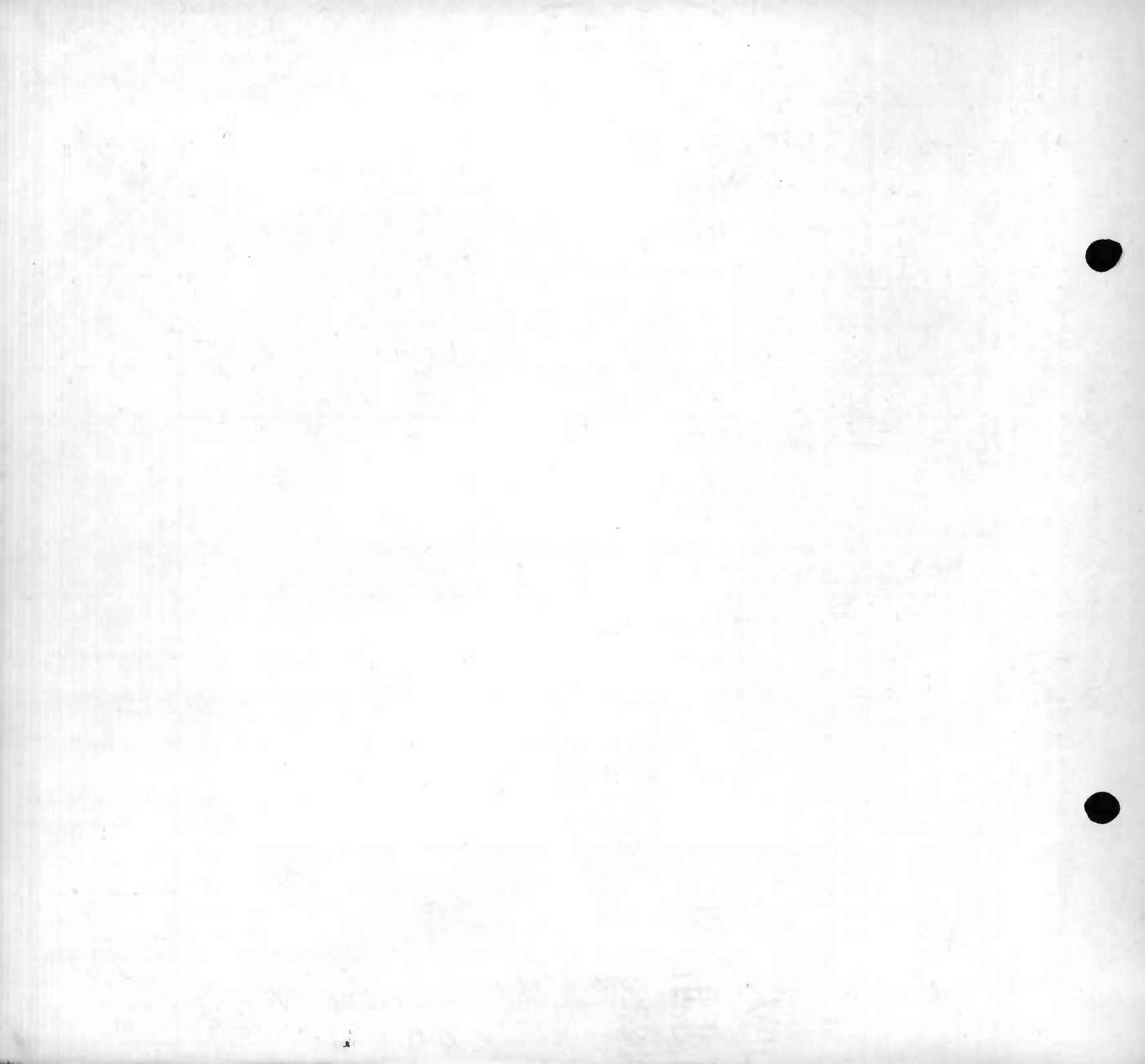
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BALTIMORE CITY HEALTH DEPARTMENT

68- 6506 CERTIFICATE OF DEATH

REG. NO. 68- 6506

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary Charlotte Johnson</i>		2. DATE AND HOUR OF DEATH <i>June 21, 1968 12 Noon</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>22-01</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Nov. 22, 1913</i>		9. AGE (In years last birthday) <i>54</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Jessie Perry</i>		14. MOTHER'S MAIDEN NAME <i>Louise Taylor</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Medical Record</i>	
18. <i>199.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinomatous</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 21, 1968</i> to <i>June 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 21, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Youngsik Moon, M.D.</i>		23B. DATE SIGNED <i>June 21, 1968</i>		23C. PHYSICIAN'S NAME (Type) <i>Youngsik Moon M.D.</i>	
23D. ADDRESS <i>University Hospital</i>		23E. FUNERAL DIRECTOR <i>Charles E. Fine</i>		23F. ADDRESS <i>66 W. Barre St</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-26-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 25 1968</i>		25B. NAME OF REGISTRAR <i>R. E. Taylor</i>	



68-6507

BALTIMORE CITY HEALTH DEPARTMENT

68-6507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EVA MIDGETT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 21, 1968 9:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 552 St. Mary's Street		3. DATE PRONOUNCED DEAD Month Day Year June 21, 1968 9:20 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/28/28		10. AGE (In years lost birthday) 40	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? unk.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME unk.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Walter Midgett	
19. CAUSE OF DEATH Pulmonary Tuberculosis		ADDRESS 3838 Cottage Ave.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Charles A. Rice	
25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.			

4/28/38 40

Virginia
Wm.

Walter Hildner 3838 Cottage Ave.

Walter Hildner

WALTER HILDER

Walter Hildner

Walter Hildner, Baltimore, Maryland
Walter Hildner, 681 W. 1st St.
Walter Hildner, 681 W. 1st St.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		68-6508	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LEONA SMITH				6/23/68 6:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
4940 Eastern Avenue Baltimore, Maryland 21224 31 Baltimore City Hospitals				Md. 19-04			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				602 S. Fulton Ave. Md. 21217			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		NEGRO		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9-19-07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
UNEMPLOYED.				Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CALEB.				EFFIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Baltimore, City Hospitals Records: 4940 Eastern Ave. Balto., Md. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Severity, Arthritis, decubitus ulcers.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (if this hospital) attended the deceased from 6/10/1968 to 6/23/1968, that (we) last saw the deceased alive on 6/22/68, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Chris Economides				6/23/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
C.G. ECONOMIDES				BALTIMORE CITY HOSPITAL 4940 Eastern Ave. Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/28/68		Mt. Calvary		Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 25 1968		Charles E. Taylor		Charles A. Rice 661 W. Barre St.			

RECEIVED
JAN 10 1960
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

1-10-60
JAN 10 1960
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6509

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIE GREENSHAW		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968		Hour 5:40 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1424 E. Lanvale Street		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1968		Hour 5:40 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-09	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Sept 25-1906		10. AGE (In years lost birthday) 65		11. BIRTHPLACE (State or foreign country) Union S.C. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Orenshaw		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Seather Jeter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-0-7609		18. INFORMANT Seather Jeter		ADDRESS	
19. 150X I		CAUSE OF DEATH Carcinoma of Esophagus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19. 150X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE Ronald N. Kornblum		M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		June 22, 1968	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 27/68		24C. NAME of CEMETERY or CREMATORY Int Calvary Cemetery		24D. LOCATION (City, town, or county) (State) a a Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR Robert E. Williams		ADDRESS 1701 N Bond St	

10-2-1904

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

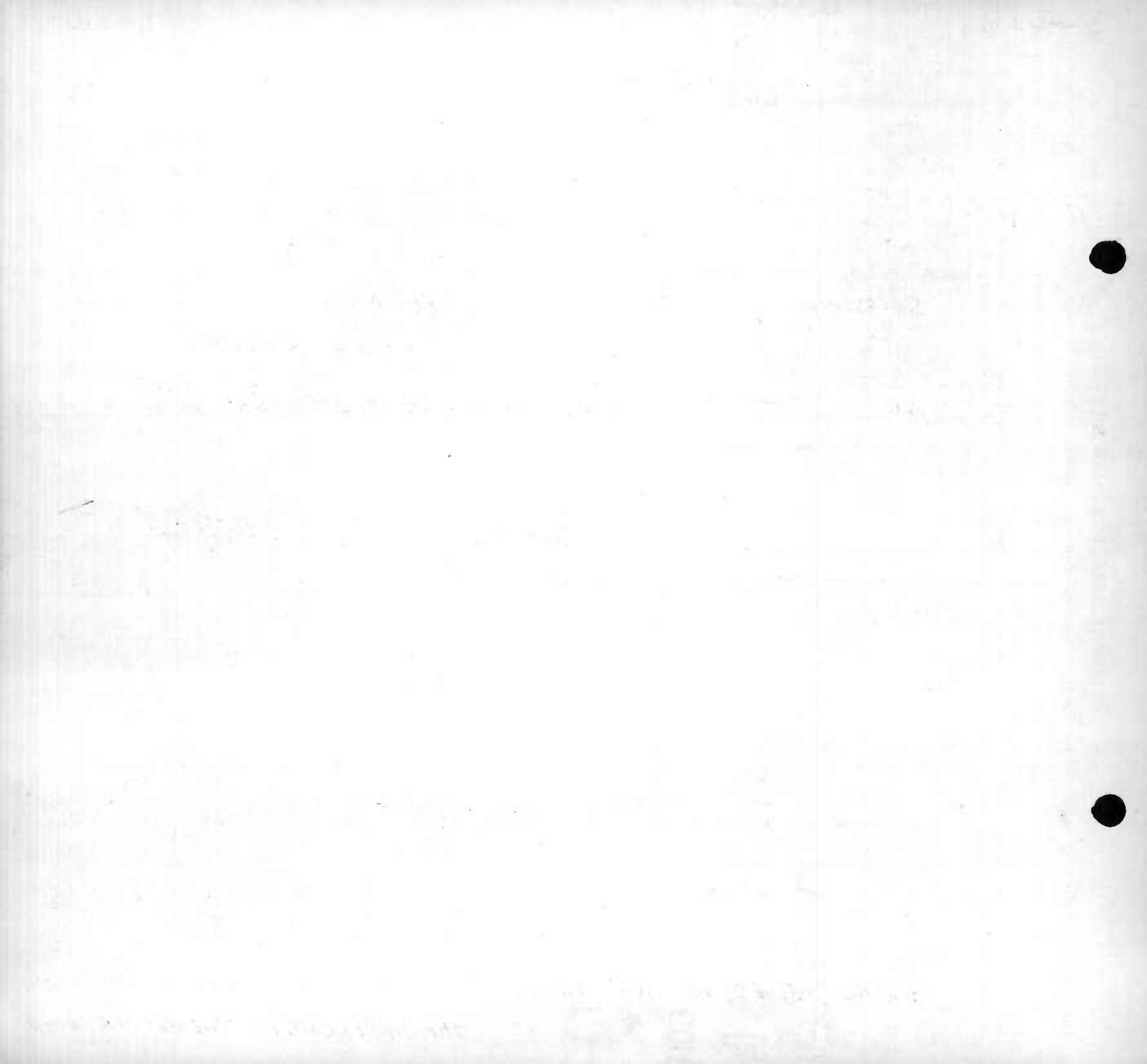
68- 6510 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

68- 6510

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. GEORGE J. SHINOSKY		2. DATE AND HOUR OF DEATH 6/22/68 1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 9-03		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. General Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3603 Greenmount Avenue		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/87	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Florian Shinosky		
14. MOTHER'S MAIDEN NAME ANNA KINDEL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 199-09-4154			17. INFORMANT LOUISE M. SHINOSKY		
ADDRESS 3603 GREENMOUNT AVE			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 4201 I			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 4201 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/20/1968 to 6/22/1968 , that (I) (we) last saw the deceased alive on 6/22/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6/22/68	
23C. PHYSICIAN'S NAME (Type) S. SWAROOP MD				23D. ADDRESS Md. Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 25 68		24C. NAME of CEMETERY or CREMATORY HOLY CROSS CEMETERY	
24D. LOCATION (City, town, or county) (State) GERMAN HILL RD BALG MD		25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR THE DIRPEL BROS INC 7110 BELAIR ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>68-6511</u>
BIRTH NO. _____		2. DATE AND HOUR OF DEATH <u>JUNE 23, 1968</u> <u>12:10PM</u>		
1. NAME OF DECEASED (Type or Print) <u>CAROLINA O'HARA, LENA P.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-5230</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF DECEASED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVES.</u> <u>BALTIMORE, MD. 21229</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>3005 GEORGETOWN RD.</u>		9. AGE (In years last birthday) <u>39</u>		
S. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 03 28</u>	10. AGE (In years last birthday) <u>39</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ERICOLE CORROPOLI</u>		
14. MOTHER'S MAIDEN NAME <u>ELVIRA CORVINE III</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/O</u>		
16. SOCIAL SECURITY NO. <u>215-24-0857</u>		17. INFORMANT <u>BALTO., MD. 21229</u> <u>ST. AGNES RECORDS-CATON & WILKENS AVES</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>486X I</u> <u>Congestive heart failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>490X II</u> <u>Toxic myocarditis</u> <u>Bacterial pneumonia right chest</u> <u>associated with emphysema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>490X II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 20</u> <u>19 68</u> to <u>JUNE 23</u> <u>19 68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JUNE 23</u> <u>19 68</u> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Herbert J. Levickas</u>		23B. DATE SIGNED <u>6/23/68</u>		23C. ADDRESS <u>5404 East Drive</u> <u>(21227)</u>
23D. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-27-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTO. NATIONAL CEM.</u>
24D. LOCATION (City, town, or county) <u>BALTO MARYLAND</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 25 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>WEBER FUNERAL HOME Edmondson Ave</u>

Marriage Record of Eugene J. O'Hara and Caro-
lina Corropoli from St. John the Baptist
Church dated June 8, 1947 3-25-69 M.YH.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released as Non Med for the Medical Examiner's Office per Dr. Kornblum MEDICAL CERTIFICATION

T-520 68-6512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6512	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary Ann Thomas		2. DATE AND HOUR OF DEATH 6/21/68 1:50 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 5415 McCormick Ave. 53-00	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/29	9. AGE (In years last birthday) 39	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO. MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Winkler		14. MOTHER'S MAIDEN NAME Eva Mezewski	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 26-8538		17. INFORMANT FRANK M. Thomas	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if giving rise to the above cause (A) UNDERLYING CONDITION last. Grand Exogenous Obesity		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/68 to 6/21/68 , and that (I) (we) lost saw the deceased alive on 6/21/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) NOT view the body after death.					
23A. SIGNATURE Dr. Albert B. Einstein, Jr.		23B. DATE SIGNED 6/21/68		23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Einstein, Jr.	
23D. ADDRESS The Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 25 1968	
24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) 7300 GERMAN HILL RD BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR THE DIPPER BROS INC		25D. ADDRESS 7110 BELAIR RD	

Grand Experiences Class
Primary/Elementary

Mr. J. M. B.

FUNERAL DIRECTOR: IMPORTANT

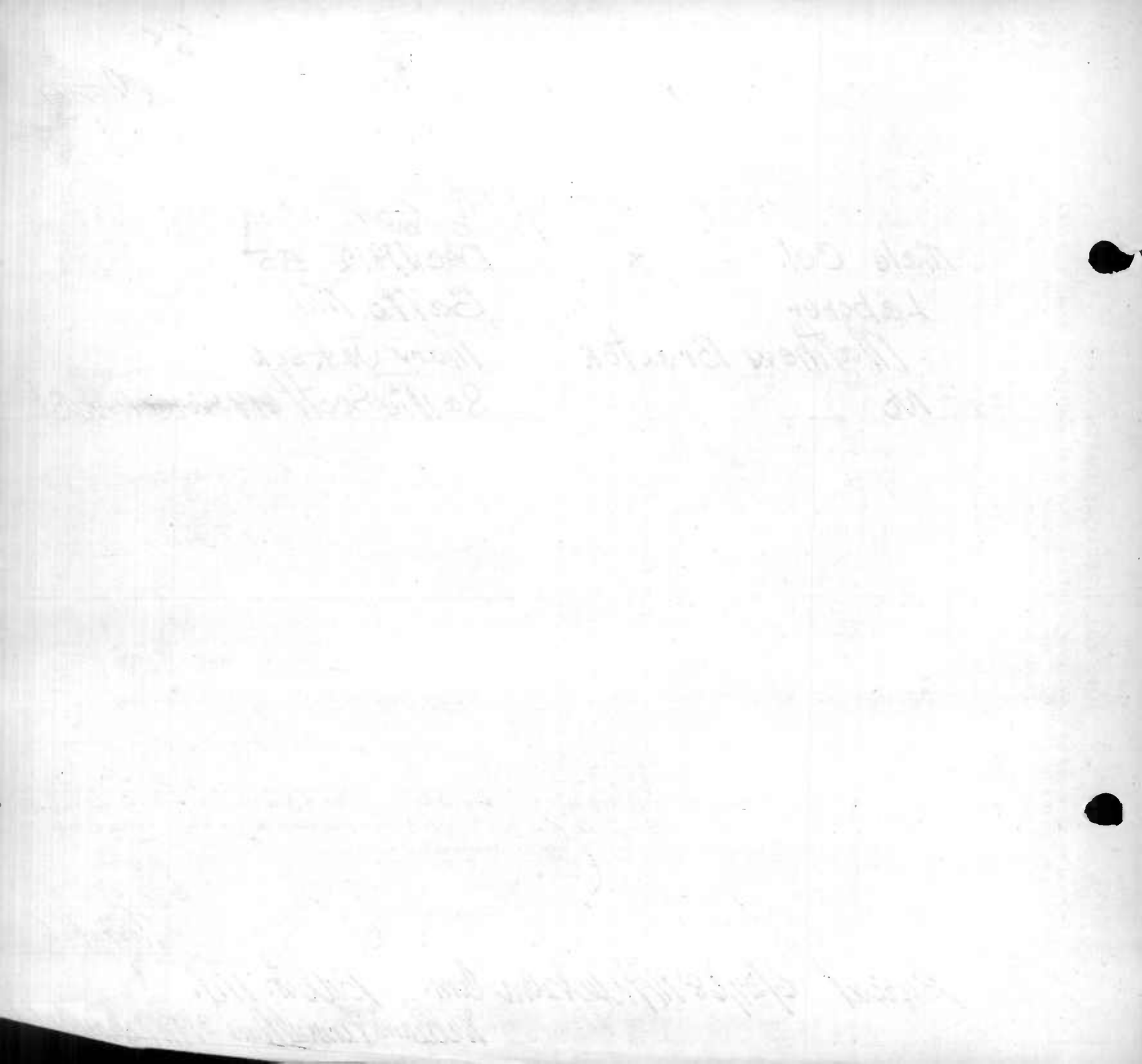
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6513

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 6513

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Jackson, Joseph</i>		2. DATE AND HOUR OF DEATH <i>6-23 1968 1:00 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>16-03</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>Col.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>55</i>	
11. BIRTHPLACE (State or foreign country) <i>Ba No. Md.</i>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Matthew Braxton</i>	
14. MOTHER'S MAIDEN NAME <i>Mary Jackson</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sallie Scott</i>		ADDRESS <i>614 S. E. 1st St.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Hepatic Coma</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Primary hepatoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>153.0 II</i>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>6/22 1968</i> to <i>6/23 1968</i> , that (I) (we) last saw the deceased alive on <i>6/23 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Nak Joory</i>		23B. DATE SIGNED <i>6-23</i>		23C. PHYSICIAN'S NAME (Type) <i>Nak Joory</i>	
23D. ADDRESS <i>Franklin Square Hospital</i>		24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/27/68</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Franklin Square</i>		24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		(State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 25 1968</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Williams Funeral Home</i>	
25D. ADDRESS <i>3199</i>					



15-425

68-6514

BALTIMORE CITY HEALTH DEPARTMENT

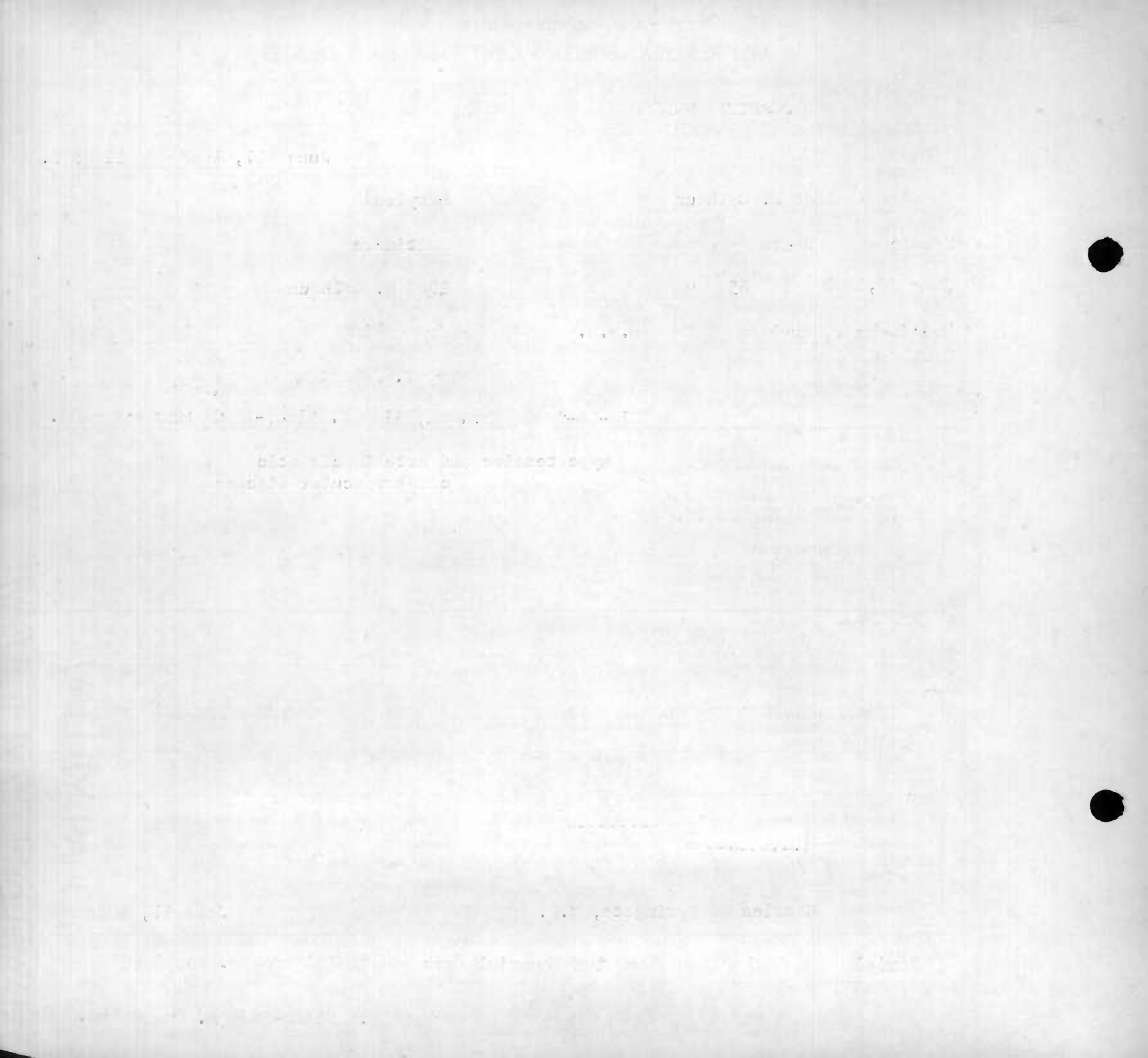
68-6514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JUANITA KELSON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1348 N. Calhoun				3. DATE PRONOUNCED DEAD Month Day Year Hour June 17, 1968 11:05 A.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-01				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1348 N. Calhoun	
9. DATE OF BIRTH June 16, 1902		10. AGE (In years last birthday) 65		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew King		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Mary T. Johnston		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-56-1292		18. INFORMANT Mrs. Phyllis A. Diggs		19. CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		20. DATE OF OPERATION 6/21/68	
21. AUTOPSY? (Yes or No) No		22. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		23. HOW DID INJURY OCCUR?		24. DATE REC'D BY HEALTH DEPT. JUN 25 1968	
25. NAME OF REGISTRAR Robert E. Springate		26. FUNERAL DIRECTOR Herbert E. Nutter		27. ADDRESS 3035 W. North Ave.		28. DATE 6/21/68	
29. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		30. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		31. DATE 6/21/68		32. NAME OF REGISTRAR Robert E. Springate	
33. FUNERAL DIRECTOR Herbert E. Nutter		34. ADDRESS 3035 W. North Ave.		35. DATE 6/21/68		36. NAME OF REGISTRAR Robert E. Springate	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6515				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 08- 6515	
1. NAME OF DECEASED (Type or Print) ELIZA BEVERLY				2. DATE AND HOUR OF DEATH JUNE 19, 1968 12:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6-28-68 00 719 West Lafayette Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore, C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-03 D. STREET ADDRESS (If rural, give location) 719 W. Lafayette Ave.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 6/17/68 1895	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - HOME			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CAROLINE, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM L. CHILDS				14. MOTHER'S MAIDEN NAME MARY LIZZIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-10-1833-D		17. INFORMANT ADDRESS MRS. THOMAS BEVERLY 3112 Tioga Parkway		
18. 159X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF GASTROINTESTINAL TRACT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
18. 159X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROSIS (GENERALIZED)				(B) DUE TO			
18. 159X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/12 19 66 to 6/19 19 68 , that (I) (we) last saw the deceased alive on 6/19 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Gilbert L. Banfield M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/21/68	
23C. PHYSICIAN'S NAME (Type) Dr. Gilbert L. Banfield				23D. ADDRESS M.D. 722 N. Fulton Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/23/68		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Robert E. Nutter		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter - 3035 West North Ave			

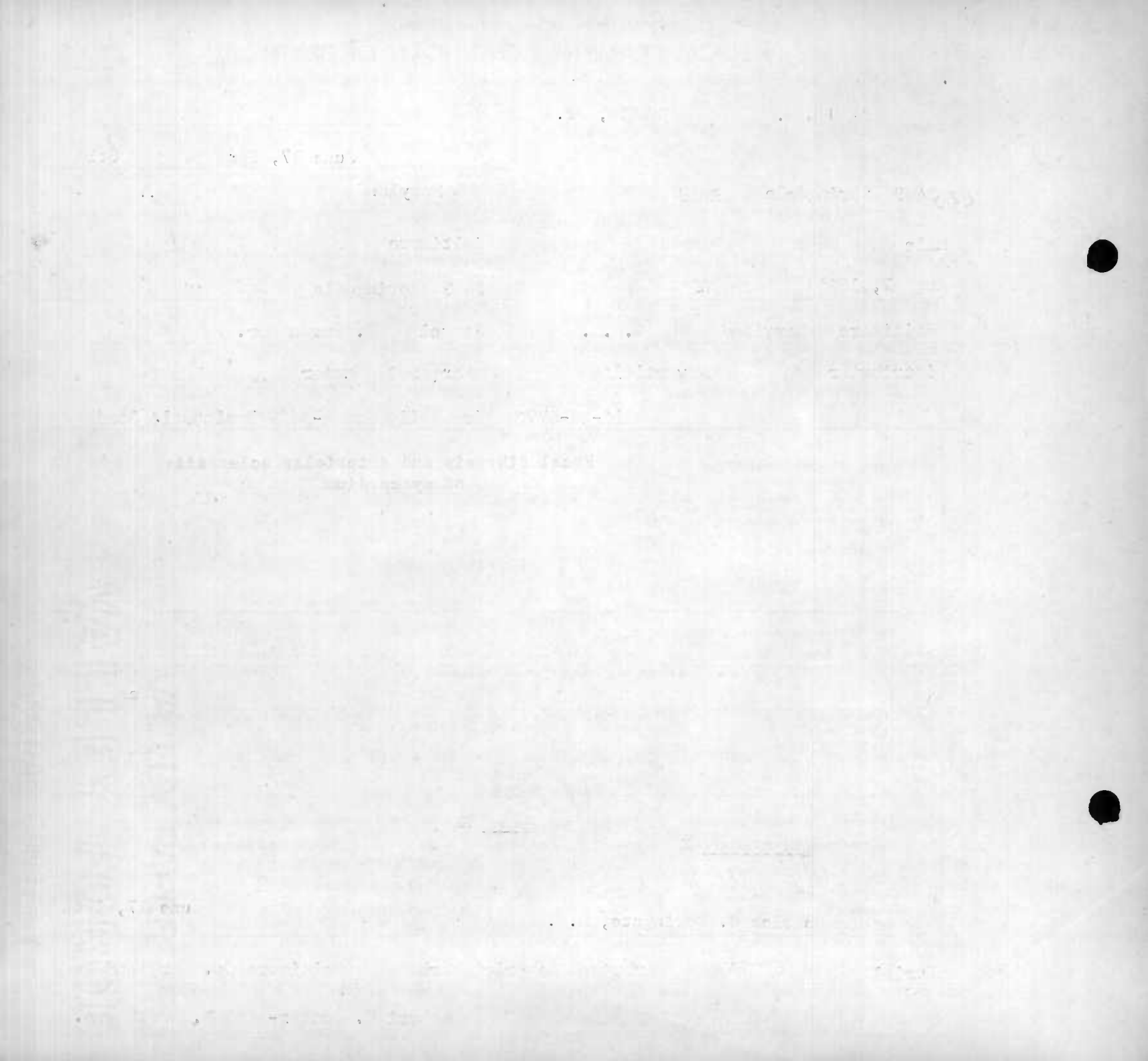
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6516

BIRTH NO.

REG. NO.

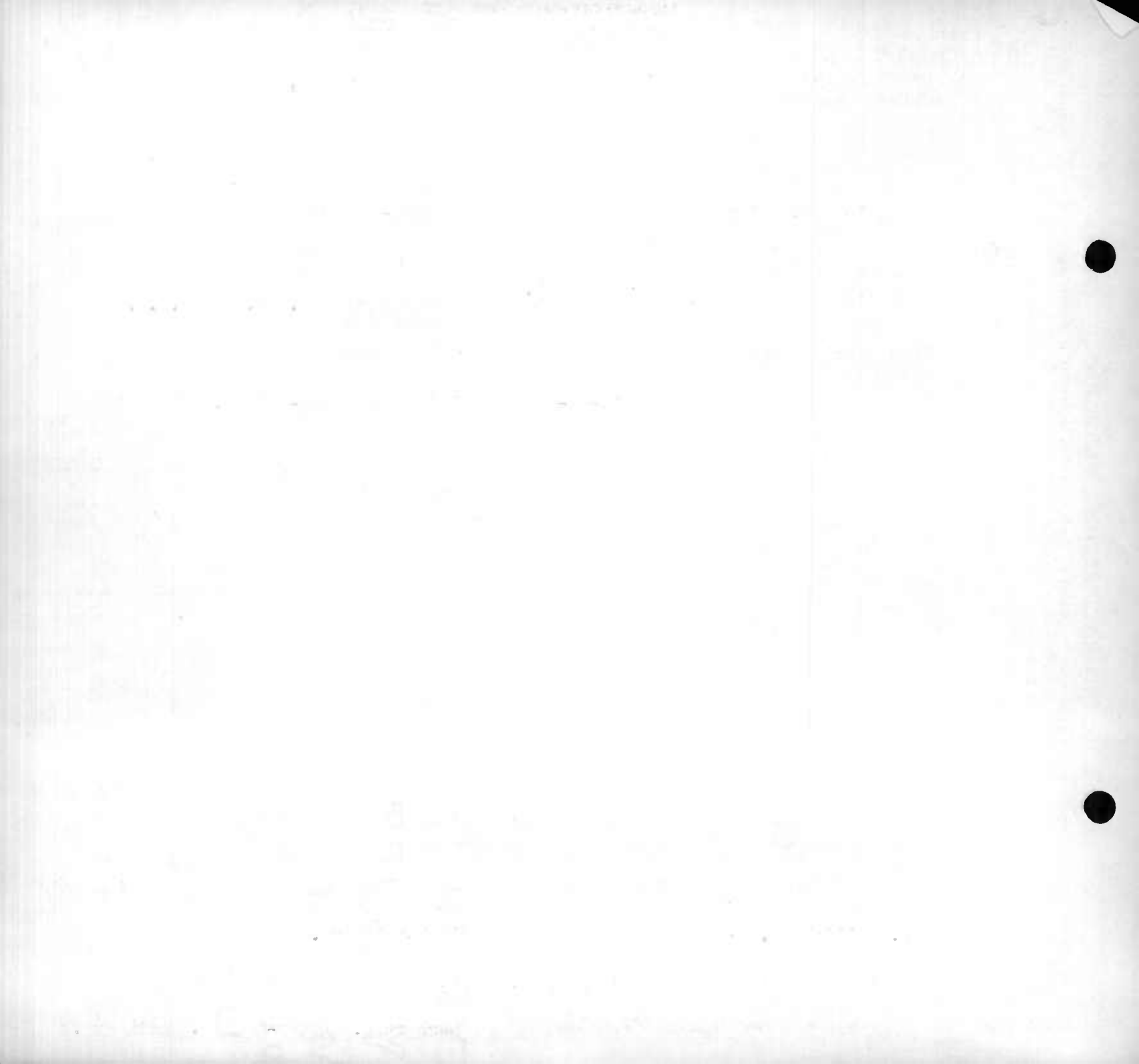
1. NAME OF DECEASED (Type or Print) SAMUEL H. BROWN, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3409 Springdale Road		3. DATE PRONOUNCED DEAD Month Day Year Hour June 17, 1968 8:10 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug 7, 1935		10. AGE (In years lost birthday) 33 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor		148. KIND OF BUSINESS OR INDUSTRY Advertising	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-32-5773	
15. MOTHER'S MAIDEN NAME Margaret Hunter		18. INFORMANT Miss Emily Brown-3409 Springdale Road	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Focal fibrosis and arteriolar sclerosis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1		(A) IMMEDIATE CAUSE of myocardium DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/22/68	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Herbert E. Nutter	
25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>68-6517</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>68-6517</u> CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Howard Lee Westbrook</u>			2. DATE AND HOUR OF DEATH <u>June 21, 1968</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1316 Eutaw Place</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1316 Eutaw Place</u>		
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>July 16, 1917</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Rogers Forge - Apt. Bldg</u>		11. BIRTHPLACE (State or foreign country) <u>South Hampton Co. Va.</u>	
13. FATHER'S NAME <u>John Wesley Westbrook</u>			14. MOTHER'S MAIDEN NAME <u>Nealie Boone</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>231-10-4277</u>		17. INFORMANT ADDRESS <u>Eulala Westbrook-1316 N. Eutaw Place</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Probable Acute myocardial infarction</u> DUE TO _____ (B) <u>ASH-D</u> DUE TO _____ (C) _____		
18. INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>10/67</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>20.1 II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> <u>10/27</u> 19 <u>68</u> to <u>6/21</u> 19 <u>68</u>, that (I) (we) last saw the deceased alive on <u>6/4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elijah B. Saunders - M.D.</u>				23B. DATE SIGNED <u>6/24/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Elijah B. Saunders</u>		23D. ADDRESS <u>3414 Duvall Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/25/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 25 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Tatter</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Herbert E. Nutter-3035 W. North Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 6518 CERTIFICATE OF DEATH

REG. NO. 68- 6518

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WELSH, RICHARD JOHN		2. DATE AND HOUR OF DEATH June 24, 1968 12:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5130 Harford Rd.	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-87	9. AGE (In years last birthday) 80	If Under 1 Yr. If Under 24 Hrs. Month Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Balto. City Employee		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Richard Welsh		14. MOTHER'S MAIDEN NAME Katherine Egan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/29/18 to 6/7/19		16. SOCIAL SECURITY NO. 217-48-4661		17. INFORMANT Records VAH, 3900 Loch Raven Blvd., Balto., Md. 21218	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 222.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE 0 Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF: with infarction (B) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
19A. DATE OF OPERATION 6/23/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED femoral embolectomy, left		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 5, 19 68 to June 24, 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 24, 19 68 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred P. Weinfeld, M.D.		23B. DATE SIGNED June 24, 1968		23C. PHYSICIAN'S NAME (Type) ALFRED P. WEINFELD, M.D.	
23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218		24. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 21214	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6519

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

REG. NO.

68- 6519

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Loretta Elizabeth Whelan		6-22-68 8 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY	
				Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
90 Gould Convalesarium 6116 Belair Rd.				Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 100 W. Cold Spring Lane	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-13-97	70	68- 6519
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
School Teacher				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James J. Whelan		Honora A. Conroy		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				James J. Whelan, III, 302 Fountain Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Coma Cirrhosis of Liver 1 wk. 5 yrs	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				3-8-10 II Fract. Metatarsals Rt foot 3 wks	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		100 W. Cold Spring Lane	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
June 6 1968 3 P.M.		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fall gully not 7' hd.	
22. I certify that (I) (this hospital) attended the deceased from 19 67 to 19 68, that (I) (we) last saw the deceased alive on 6/21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles E. Carr, Jr., M.D.				6/24/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Charles E. Carr, Jr., M.D.		3900 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-26-68		New Cathedral	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 24 1968		John E. Taylor		Leonard J. Ruck, Inc., 5305 Harford Rd.	

10/10/10

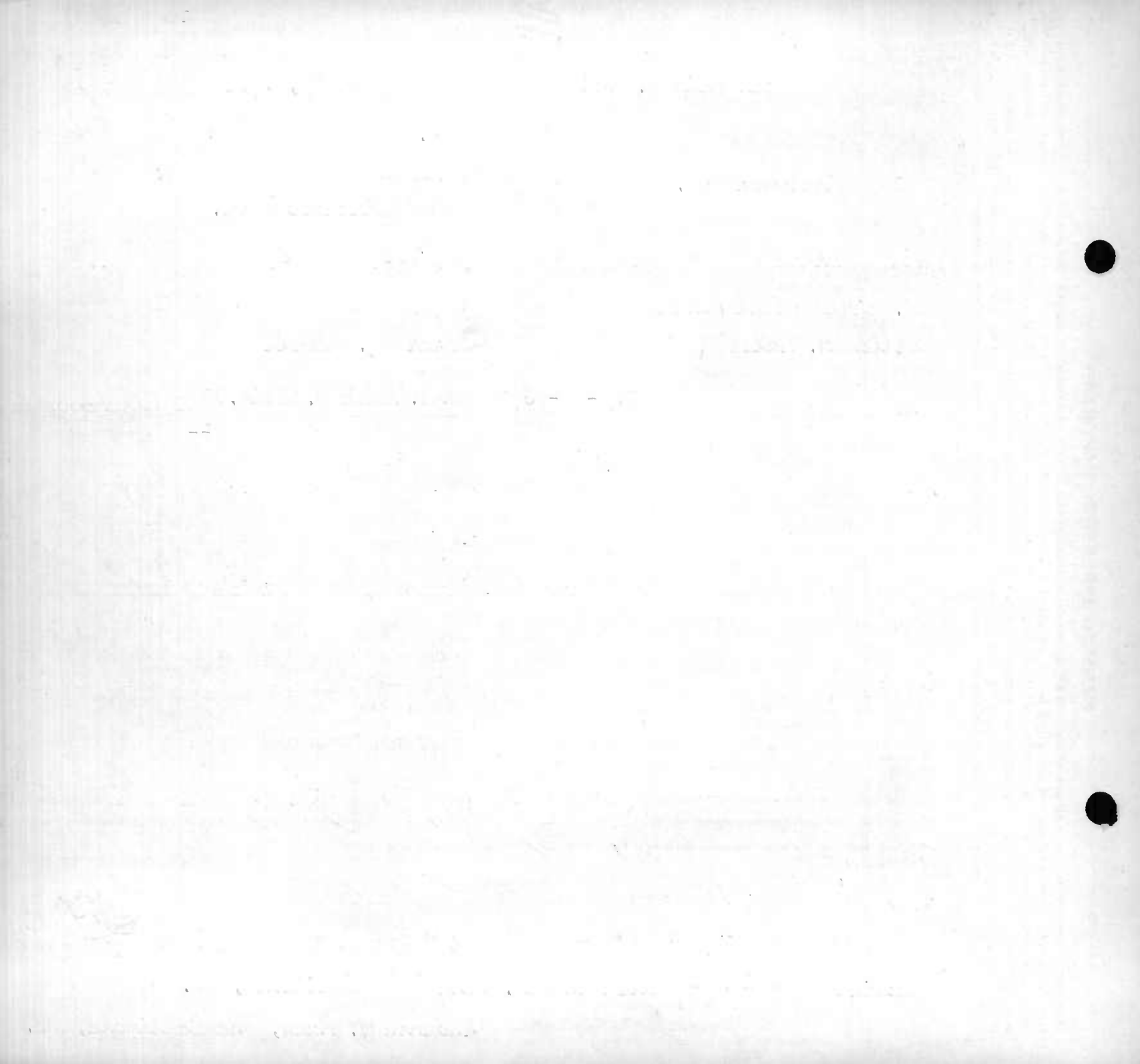
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6520 CERTIFICATE OF DEATH

REG. NO. 68- 6520

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Benjamin M. Hulse		June 23, 1968 11:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 6202 Birchwood Ave.				Md. 27-06	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Ret. sheet metal worker				2/9/1884	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
Maryland		USA 6521		84	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		If Under 1 Yr. Months Days	
William H. Hulse		Sarah E. Atwell		It Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		215-03-0892		Mrs. Helen J. Stein. 6202 Birchwood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		1. Arteriosclerotic heart 2- Dilated cardiomyopathy (B) Due to, or as a consequence of: C. Embolism, D. Etc. E. Generalized arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1955 to June 23, 1968, that (I) (we) last saw the deceased alive on June 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Donald W. Mintzer				6/24/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DONALD W. MINTZER				3009 EVERGREEN AVE BALTO MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/26/68		Moreland Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 20 1968		Charles E. Fairbanks		Leonard J. Ruck, Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 6521

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LENA J. TAUBER		2. DATE AND HOUR OF DEATH June 25, 1968 12:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 20308 7-01			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2724 North Charles St.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-26-92 9. AGE (In years last birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Borneman		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-056086		17. INFORMANT B Mr. Frank C. Tauber ADDRESS (Same)	
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE: Cerebrovascular Accident (B) Generalized Arteriosclerosis (C) Left lower extremity amputated		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19-68 19 to 6-25-68 19, that (I) (we) last saw the deceased alive on June 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. B. Paulino M.D. DEGREE				23B. DATE SIGNED 6-25-68	
23C. PHYSICIAN'S NAME (Type) Hipno, Juri		23D. ADDRESS M.D. (Attending) 5002 Frankford Ave. Balto 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/68		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6522 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6522

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JUNGBLUT, WILLIAM C.		2. DATE AND HOUR OF DEATH 624-68 130 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTE		5. SEX Male 6. RACE White	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8-26-96		9. AGE (In years lost birthday) 71		10. BIRTHPLACE (State or foreign country) Maryland	
11. CITY OR TOWN BALTIMORE		12. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. CITIZEN OF WHAT COUNTRY? USA	
14. STREET AND NUMBER 1633 JEFFERS Rd.		15. FATHER'S NAME Fritz Jungblut		16. MOTHER'S MAIDEN NAME Margaret Zinn	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 213-09-0205		19. INFORMANT Mrs. Madeline Jungblut	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction & Renal Shut Down (B) DUE TO, OR AS A CONSEQUENCE OF: Ruptured Abdominal Aortic Aneurysm 2 days (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 45-1X II					
19A. DATE OF OPERATION 6/22 6/23		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Aortic Aneurysm		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/22 19 68 to 6/24 19 68 , that (1) (we) last saw the deceased alive on 6/24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joe U. Levi M.D.		23B. DATE SIGNED 6/24/68.		23C. PHYSICIAN'S NAME (Type) Joe U. Levi M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.		25D. ADDRESS Balto. Md. 21214		25E. DATE OF DEATH 6/24/68	

1974

62423

WILLIAM W. WILSON

MD
BALTIMORE
1033 JEFFERS RD.
8-26-86

JOHN HARRIS HOSPITAL
V
M W

Residential Information
Rental Unit 2000
Rapidway Building State University

812 213 Rapidway State University

PL 24

PL 24

PL 24

PL 24

PL 24

MD

Joe M. Love MD

Joe M. Love MD

7HH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6523

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Norris, Margaret Horn</i>		2. DATE AND HOUR OF DEATH <i>6/24/68 9:55 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> City <i>21-09</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore 21218</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>FEMALE</i> 6. RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/27/63</i> 9. AGE (In years, lost birthday) <i>64 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND, BALTO. CO.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>GEORGE S. HORN</i>		14. MOTHER'S MAIDEN NAME <i>Katherine D. Baker</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO.</i>	
16. SOCIAL SECURITY NO. <i>214-18-7216</i>		17. INFORMANT <i>Howard Norris (Husband)</i>		ADDRESS <i>SAME as DECEASED</i>	
18. <i>7/2/81</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE - <i>Acute myocardial Infarction old</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) - <i>A.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Pneumonia</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>X.S.</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>5/19/68</i> to <i>6/24/68</i> , that (1) (we) last saw the deceased alive on <i>6/24/68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>DERMOT CAMPBELL M.B.</i> DEGREE				23B. DATE SIGNED <i>6/24/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>DERMOT CAMPBELL M.B.</i> DEGREE				23D. ADDRESS <i>Union Memorial Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/27/1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>	
24D. LOCATION <i>Baltimore</i>		24E. CITY, TOWN, or COUNTY <i>Maryland</i>		24F. STATE <i>Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 25 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co.</i> ADDRESS <i>1905 York Rd. Balt., Md.</i>	

Handwritten notes at the top left, including "Handwritten notes" and "Handwritten notes".

Handwritten notes at the top right, including "Handwritten notes" and "Handwritten notes".

Handwritten notes in the middle left, including "Handwritten notes" and "Handwritten notes".

Handwritten notes in the middle right, including "Handwritten notes" and "Handwritten notes".

Handwritten notes at the bottom left, including "Handwritten notes" and "Handwritten notes".

Handwritten notes at the bottom right, including "Handwritten notes" and "Handwritten notes".

Handwritten notes at the very bottom left, including "Handwritten notes" and "Handwritten notes".

Handwritten notes at the very bottom right, including "Handwritten notes" and "Handwritten notes".

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6524

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS Anthony BAKER

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☒ June 23, 1968 8:45 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year Hour
June 23, 1968 9:18 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒ NO ☐

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

7/3/49

10. AGE (In years
lost birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1815 E. Lafayette Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Baker

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Madeline Green

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

213-52-2260 Mrs. Dorothy Sampson 1815 E. Lafayette

19. E 910.0

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenio, etc. It means the disease,
injury or complication which caused death.)

Drowning

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

water

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?2000 blk. Sinclair
Clifton Park Swimming Pool Lane22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 6/23/68 8:45 P. m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

subj. drowned

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/27/68

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUN 25 1968

Robert E. Farley

Wm C March 928 E. North Ave.

VALLEY POINT
CITY OF

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>MAGAFINE</i>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>68-6525</i>	
1. NAME OF DECEASED (Type or Print) <i>MAGAFINE, Jannie</i>				2. DATE AND HOUR OF DEATH <i>11:15 a.m. - 6-24-68</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>9-08</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lincoln Memorial Nursing Home</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>532 E. Nord Ave #18</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-12-1900</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Petersburg Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>unknown</i>			
14. MOTHER'S MAIDEN NAME <i>unknown</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>#216-24-2073</i>				17. INFORMANT ADDRESS <i>Lincoln Memorial Nursing Home 27. N. Cay St.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>433.1</i>				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>332 X II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 4</i> 19 <i>68</i> to <i>June 24</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>June 24</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jannie</i>				23B. DATE SIGNED <i>6-24-68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Harris</i>				23D. ADDRESS <i>5579 JENNISON AV BAL MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-28-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Int. Calvary Cmt</i>		24D. LOCATION (City, town, or county) (State) <i>Brooklyn Md</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>R. L. E. F. F. F.</i>		25C. FUNERAL DIRECTOR <i>E. L. G. W. L. G.</i>		ADDRESS	

232 E. Avenue #12

1900

Charles, Thelma

John Thomas

232 E. Avenue #12

51-93-66-1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6526	
BIRTH NO. 5-536 68-6526					
1. NAME OF DECEASED (Type or Print) <i>Albata Sanders</i> ALBERTA SANDERS			2. DATE AND HOUR OF DEATH 6/20/68 6:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 26-10		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 318 N. EAST STREET #21202					
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24 1880	9. AGE (In years last birthday) 88	10. If Under 1 Yr. Months Days 10 6
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Parker			14. MOTHER'S MAIDEN NAME Laura Fairfax		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-09-9864		
17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury at complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Insufficiency 2° Asphyxia pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Malnutrition & Dehydration 3 years (C) Chronic Bronchial Syndrome		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 286.5 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) [this hospital] attended the deceased from 6-14-68 19 to 6-20-68 19, that (I) [we] last saw the deceased alive on 6-20-68 19 and that in (my) [our] opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Juan</i>			23B. DATE SIGNED 6/20/68		
23C. PHYSICIAN'S NAME (Type) DAVID JUAN M.D.			23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/24/68		
24C. NAME OF CEMETERY or CREMATORY Mount Auburn			24D. LOCATION Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968			25B. NAME OF REGISTRAR DONALD E. GLOVER		
25C. FUNERAL DIRECTOR ADDRESS 1701 N. PATTERSON PK.					

10-20-68

10-20-68

10-20-68

10-20-68

10-20-68

10-20-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6527 CERTIFICATE OF DEATH

REG. NO. 68- 6527

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY AGNES FLAHERTY		2. DATE AND HOUR OF DEATH June 24, 1968 8:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3611 Hayward Av. Baltimore, Md.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F 6. RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion			10B. KIND OF BUSINESS OR INDUSTRY Domestic		9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Vincent Flaherty			14. MOTHER'S MAIDEN NAME Anastasia Hayes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 197-12-9078		17. INFORMANT Alice Edmonds (sister) ADDRESS same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 43791 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Stroke		6 weeks
(C) Cerebral Arteriosclerosis					Unknown
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 334X II					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 10, 1968 to 6/24 1968 , that (I) (we) last saw the deceased alive on 6/24 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. W. Stewart			23B. DATE SIGNED 6/24/68		
23C. PHYSICIAN'S NAME (Type) D. W. STEWART			23D. ADDRESS SINAI HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/1968		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR Robert E. Taylor			
25A. DATE RECD BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR LeComme	
ADDRESS 4611 Park Heights Ave.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

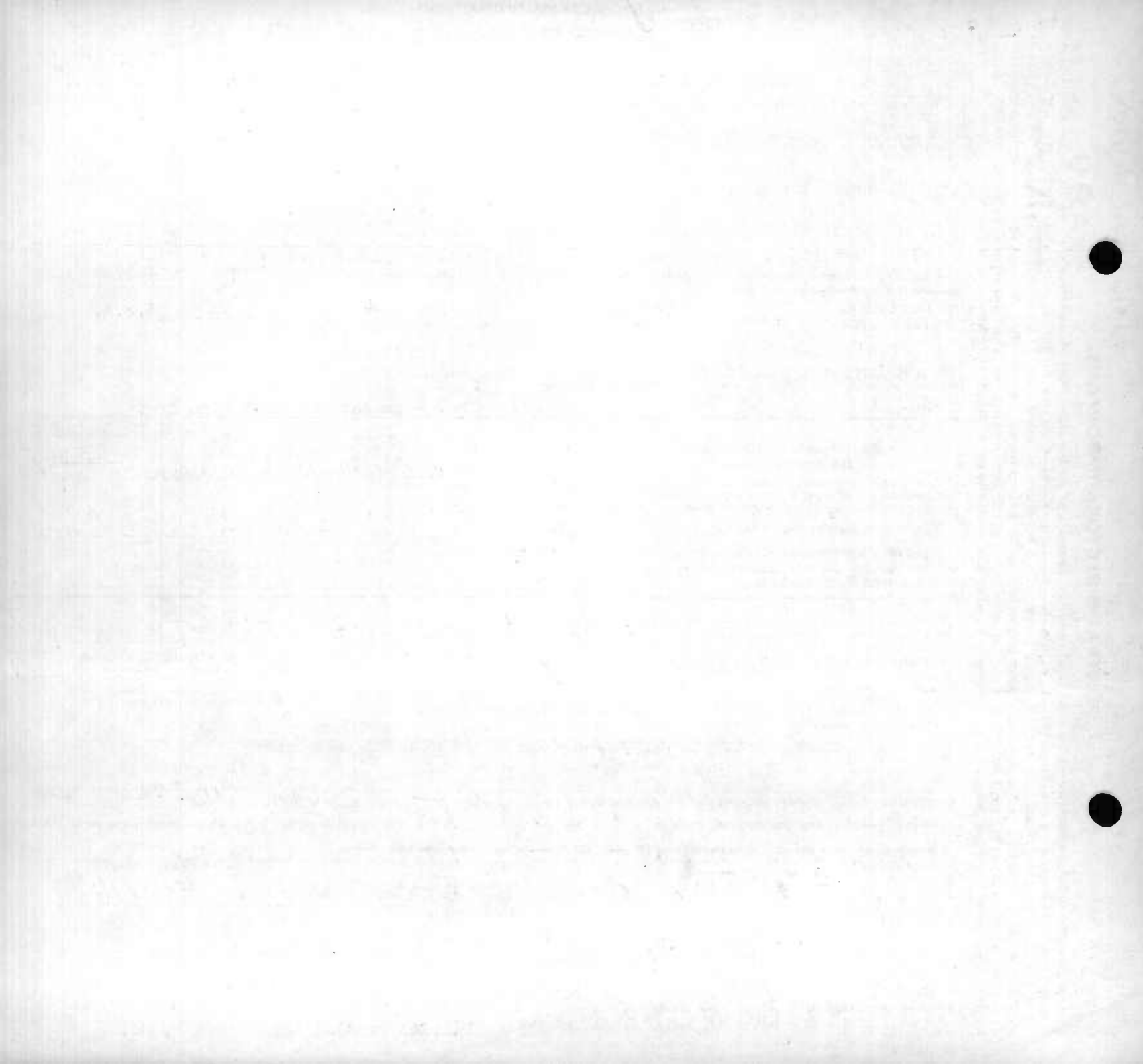
G-260		68-6528		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6528	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GESSER, RAYMOND				2. DATE AND HOUR OF DEATH 6/22/68 10:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (If not in hospital or institution, give street address or location) 6-26-68 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 26-36 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1219 GUSRYAN STREET #21224			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-26-13	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 55		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD GESSER				14. MOTHER'S MAIDEN NAME LILLIAN BOSS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-09-5391		17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD	
18. 25-0-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardio - pulmonary arrest - ? etiology. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: D.M., old T.B., anemia, mild (B) renal failure. DUE TO, OR AS A CONSEQUENCE OF: (C) Old peptic ulcer disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/13/67 to 6/22/68 that (I) (we) last saw the deceased alive on 6/22/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Z. Grossman				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/22/68	
23C. PHYSICIAN'S NAME (Type) ZACHARY GROSSMAN M.D.				23D. ADDRESS 21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/25/68		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 25 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.		ADDRESS	

Letter from City Hospital
6-26-68 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6529
68- 6529				CERTIFICATE OF DEATH
BIRTH NO. 12				
1. NAME OF DECEASED (Type or Print) WALTER J. JACOBS		2. DATE AND HOUR OF DEATH June 22, 1968 7:30 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6605 Pine Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-36		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 6605 Pine Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1910	9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Don't know		14. MOTHER'S MAIDEN NAME Don't Know		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-09-1556		17. INFORMANT Mrs. Edna Jacobs, 6605 Pine Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4/10/91 CAUSE OF DEATH CORONARY Occlusion 5min		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive + A-S-C-V - Disease - Cerebral (B) DUE TO, OR AS A CONSEQUENCE OF: Accident - Feb 24 - 1967 (C) II		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A).				
19A. DATE OF OPERATION 4/20/11		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Accident		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 1962 to June 22 1968 , that (I) (we) last saw the deceased alive on June 17 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE M.B. Davis, M.D.		23B. DATE SIGNED 6/22/68		23C. PHYSICIAN'S NAME (Type) M.B. Davis, M.D.
23D. ADDRESS 6800 Morningside Road,				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/24/68	24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	24D. LOCATION (City, town, or county) (State) Colgate, Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 6530	
BIRTH NO.		68- 6530		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		68- 6530		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		RAYMOND SPROUL		2. DATE AND HOUR OF DEATH June 24, 1968 9:00 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. M.	
FULL NAME OF HOSPITAL OR INSTITUTION Harford Gardens Nursing Home		A. STATE Md.		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		9-03	
		D. STREET ADDRESS (If rural, give location) 616 E. 34th St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 27, 1895	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Instant Whip Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Sproul		14. MOTHER'S MAIDEN NAME Elizabeth Garber	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 218-10-4078		17. INFORMANT Mrs. Anna L. Bateman-616 E. 34th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cerebro-vascular accident		19. CAUSE OF DEATH cerebro-vascular arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO cerebro-vascular arteriosclerosis		several yrs.	
(B) DUE TO		(C) DUE TO			
331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		congestive heart failure		several yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from June 21 1968 to June 24 1968, that (2) (we) last saw the deceased alive on June 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. Ellsworth Cook M.D.		23B. DATE SIGNED 6-24-68		23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK	
23D. ADDRESS 2431 Maryland Ave. Md.		23E. ADDRESS 2431 Maryland Ave. Balto 21218 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State) Md.			
25A. DATE RECEIVED BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave.	
25D. ADDRESS 3818 Roland Ave.		25E. ADDRESS 3818 Roland Ave.			

C. B. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

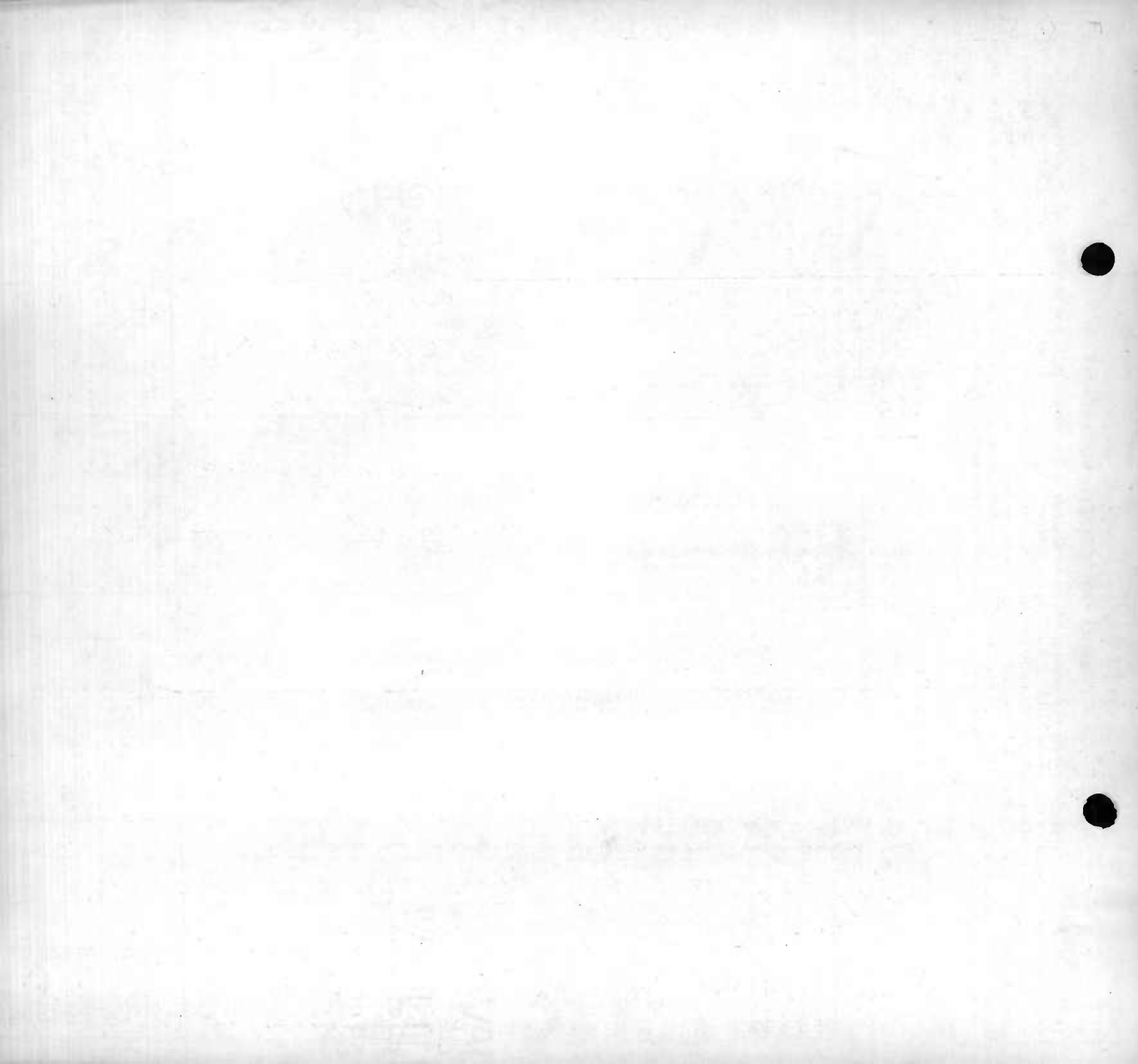
68- 6531

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 6531

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gertrude Frankle</i>		2. DATE AND HOUR OF DEATH <i>June 21, 1968</i> <i>6:34 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>			C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>3410 Delfield Ave</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/10/00</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Hyman Kushner</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
14. MOTHER'S MAIDEN NAME <i>EVA SAPOSNIK</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Jacob Frankle</i>	
				ADDRESS <i>3410 Delfield Ave</i>	
18. <i>200.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Reticulum cell lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>—</i>		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>6 mos</i>		
MEDICAL CERTIFICATION					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>200.0 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> 19 <i>68</i> to <i>6/21</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/21</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gary M. Latten M.D.</i>				23B. DATE SIGNED <i>6/21/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>GARY MARC LATTIN</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/23/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mount Montefiore</i>	
24D. LOCATION <i>Balto.</i>		24E. STATE <i>md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Sylvan S. Lewis & Son, Inc</i>	
				ADDRESS <i>9610 Reisterstown Rd</i>	



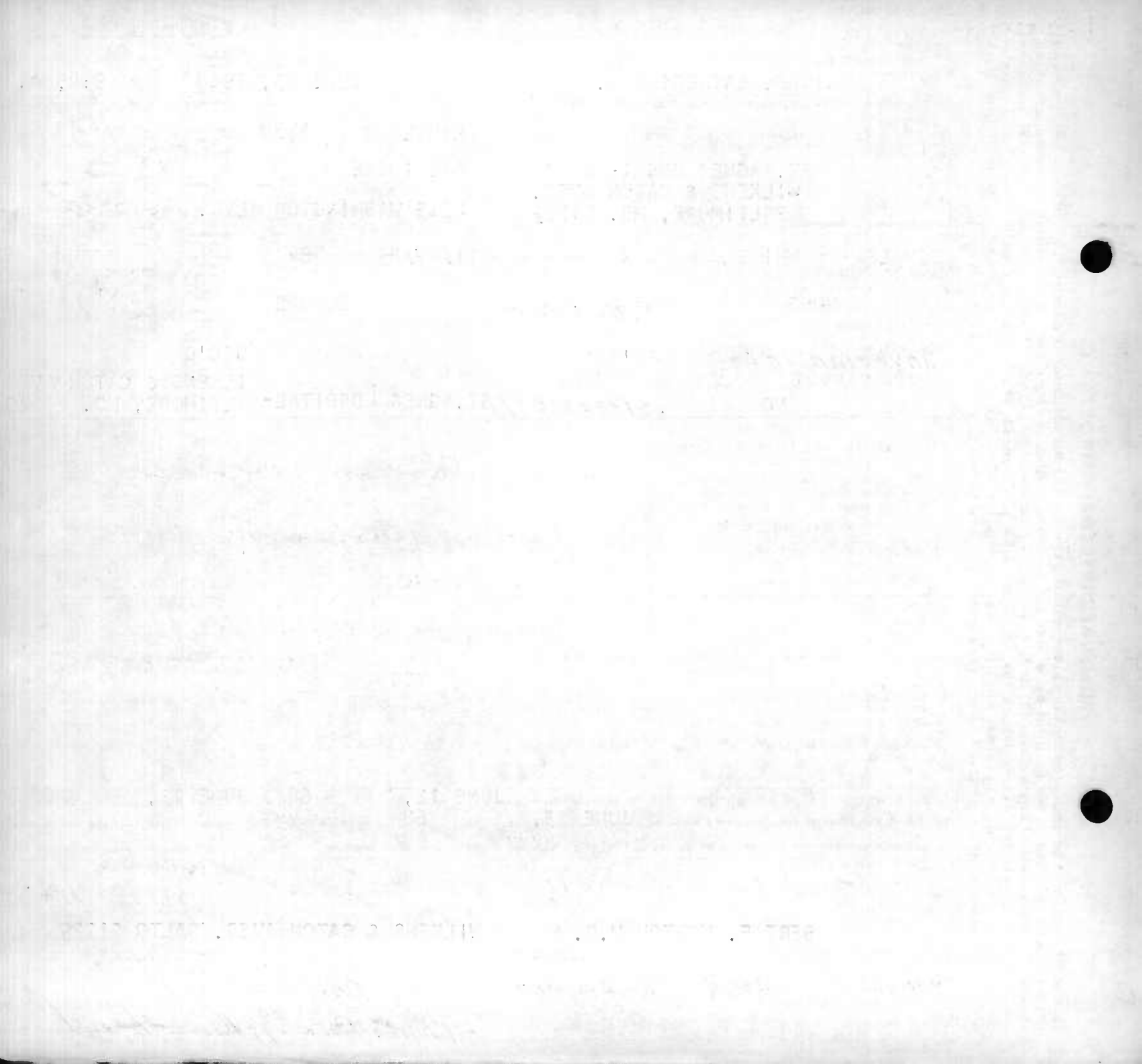
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 6532 CERTIFICATE OF DEATH

REG. NO. **68- 6532**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) NISKE, CATHERINE E.		2. DATE AND HOUR OF DEATH JUNE 23, 1968 9:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21230		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		E. STREET AND NUMBER 2519 WASHINGTON BLVD. 21230			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/07/85	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE HOUSEWIFE		11. BIRTHPLACE (State or foreign country) EUROPE	
12. CITIZEN OF WHAT COUNTRY? (?)		13. FATHER'S NAME PAUL MATTHEWS DEC'D		14. MOTHER'S MAIDEN NAME DEC'D	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 151-42-0571		17. INFORMANT WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTIMORE, MD. 21229	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bilateral pulmonary embolism (B) Thrombosis of deep femoral vein (C) Pneumonia			
19. 493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Generalized Arteriosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 12, 1968 to JUNE 23, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 23, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bert F. Morton M.D.		23B. DATE SIGNED June 23, 1968			
23C. PHYSICIAN'S NAME (Type) BERT F. MORTON M.D.		23D. ADDRESS WILKENS & CATON AVES. BALTO 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 6/25/68		24C. NAME of CEMETERY or CREMATORY GREEN MOUNT	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD					
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Albert E. Taylor		25C. FUNERAL DIRECTOR W. R. B. Bradley, Dundalk, MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 6533

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Louise M. Bransby</i>		2. DATE AND HOUR OF DEATH <i>June 23, 1968 4:20 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>23-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43</i> <i>South Baltimore General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attendant</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Public Bath</i>		8. DATE OF BIRTH <i>6-25, 1883</i>	
				9. AGE (In years last birthday) <i>84</i>	
				11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
				12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Frederick Borth</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Kahler</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Hilda Bloom</i>	
				ADDRESS <i>11 W. West St.</i>	
18. <i>7339 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Broncho PNEUMONIA</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>(1) Cerebral Thrombosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>332X II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-7-1968</i> to <i>6-23-1968</i> , that (I) (we) lost saw the deceased alive on <i>6-23-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Larry J. Warner M.D.</i>		DEGREE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>LARRY J. WARNER M.D.</i>		DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6 27 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cathedral</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>		25C. FUNERAL DIRECTOR <i>Mc Gully</i>	
				ADDRESS <i>130 E. Fort Ave</i>	

Friedrich Borch

Elizabeth Kaplan

24th Baltimore General Hospital - 11 W. Ward St.

6-22, 1893

X

W

F

10-01

X

Baltimore

6-22

6-22

6-22

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6534

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO.

68- 6534

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Caroline Pater (Potter)		June 20, 1968 10:45 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
				B. COUNTY	
60 2907 Dillon Street				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female				6. RACE White	
				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
Retired-Charwoman				Poland	
13. FATHER'S NAME Albert Ziarko				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
No				213-01-9650	
17. INFORMANT (Son)				ADDRESS	
John Pater, 921 S. Potomac St. Balto. Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Coronary Infarction			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Generalized Atherosclerosis			
		(C) Hypertensive C.O.D.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from May 10 1968 to June 20 1968, that (I) (we) last saw the deceased alive on June 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin J. Jaworski				23B. DATE SIGNED 6/21/68	
23C. PHYSICIAN'S NAME (Type) Melvin J. Jaworski M. D.				23D. ADDRESS 2711 Eastern Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/24/68		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.	

Received of
Hypocrite C.D.
Twenty Five

Jan 18 - 1892

John J. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
68- 6535				68- 6535
CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) NORMAN A. COLTON Sr.		
2. DATE AND HOUR OF DEATH 6/23/68		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital		C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		E. STREET AND NUMBER 2805 CRESTON ROAD		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/15	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ALBERT S. COLTON		
14. MOTHER'S MAIDEN NAME ELIZABETH W. NASH		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-03-2388		17. INFORMANT (Wife) Mrs. MARY COLTON ADDRESS same as deceased.		
18. 284X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) gastro intestinal bleeding		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WFLWK		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 292.4 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aplastic Anemia		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 22 19 68 to June 23 19 68 , that (I) (we) last saw the deceased alive on June 23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Enrique Cipriani M.D.		23B. DATE SIGNED 6/23/68		23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI M.D.
23D. ADDRESS 33rd + Calvert St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6/26/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.

Handwritten notes, mostly illegible due to fading. Some words like "the" and "and" are visible.

Handwritten notes at the bottom of the page, including a signature and date.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6536	
68-6536 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES N. BLATCHLEY		2. DATE AND HOUR OF DEATH 6/24/1968 3:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 9-01			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3703 Old York Road					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during month working life, even if retired) ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY PA. R.R.		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Blatchley		14. MOTHER'S MAIDEN NAME Susan Vane Barnett			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. A-872557		17. INFORMANT ADDRESS Mrs. Louise E. Blatchley-3703 Old York Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2609 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diffuse Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) Acute confluent bronchopneumonia bilateral		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNT	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/23/68 to 6/24/68 , that (I) (we) last saw the deceased alive on 6/23/68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. F. [Signature]		23B. DATE SIGNED 6/24/68		23C. PHYSICIAN'S NAME (Type) Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.	
24D. LOCATION Balto.		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert H. [Signature]	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		25D. ADDRESS 6500 York Road-21222			

2003 On York Road
 1/1/01 05
 1/1/01
 Robert H. White
 11-2000

Off. Under
 State Probation
 State Capital Building
 1001

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 1/1/01
 1/1/01
 1/1/01
 1/1/01

FUNERAL DIRECTOR: IMPORTANT

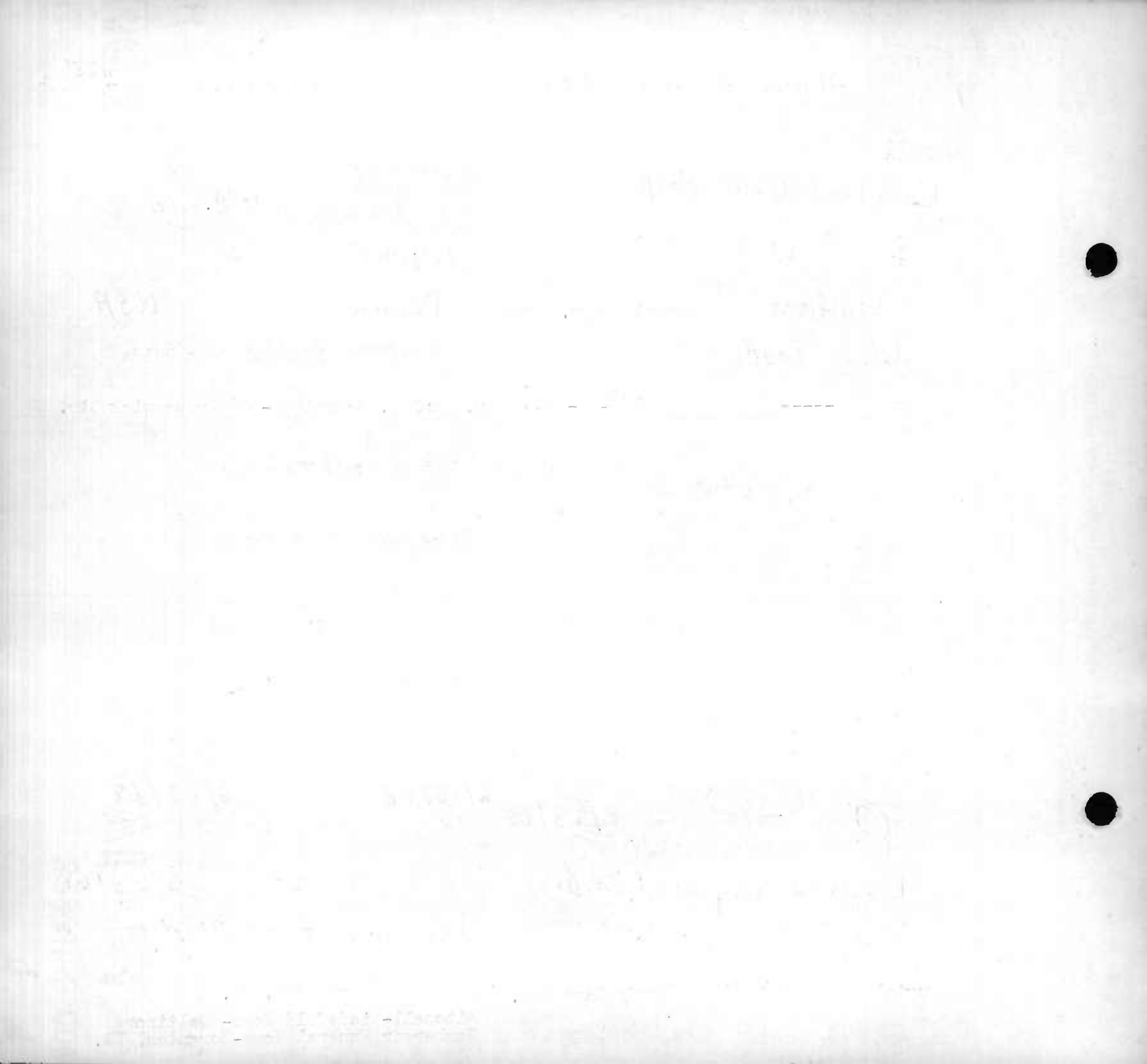
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-6537

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Alma E. Schreiber		2. DATE AND HOUR OF DEATH 6/23/68 4:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland Gen. Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 908 Breeze Wick Circle	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/1915	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY Stewarts Dept. Store		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME John Trotz			14. MOTHER'S MAIDEN NAME Anna Bulda		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 195-10-0969		17. INFORMANT ADDRESS Mr. Carl G. Schreiber-908 Breezewick Cir. 04	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Status arthmaticus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchial arthma.					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 241X II					
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/16/68 19 to 6/23/68 19, that (I) (we) lost saw the deceased alive on 6/23/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph D. Raymond, M.D.				23B. DATE SIGNED 6/23/68	
23C. PHYSICIAN'S NAME (Type) Ralph D. REYMOND				23D. ADDRESS Maryland Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/16/68		24C. NAME of CEMETERY or CREMATORY Shady Lane Cem.	
24D. LOCATION Scranton, Pa.		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR Ralph E. Farkner		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home- Baltimore Bombardier Funeral Home-Scranton, Pa.			



1
R-200

68-6538 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6538

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) CHARLES J. ROSCH, SR.2. DATE OF DEATH Known ☐ Month Day Year
Estimated ☐ June 20, 1968 3:55 P. M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE PRONOUNCED DEAD Month Day Year
June 20, 1968 3:55 P. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX
Male7. RACE
White8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐C. CITY OR TOWN
BaltimoreD. INSIDE CITY LIMITS?
YES ☒ NO ☐

9. DATE OF BIRTH

Jan. 1, 1912

10. AGE (In years
lost birthday) 56If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3704 Hudson Street # 21224 .

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

George J. Rosch

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Self

14B. KIND OF BUSINESS OR INDUSTRY
Trucking Co.

15. MOTHER'S MAIDEN NAME

Carrie T. Fleckenstein

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.
212-01-1962

18. INFORMANT

Geraldine Mae Rosch

ADDRESS

Same.

19.

CAUSE OF DEATH

Hypertensive Cardiovascular Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 21, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-24-68

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

7225 Eastern Blvd., Ba. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 26 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Charles J. Geiler

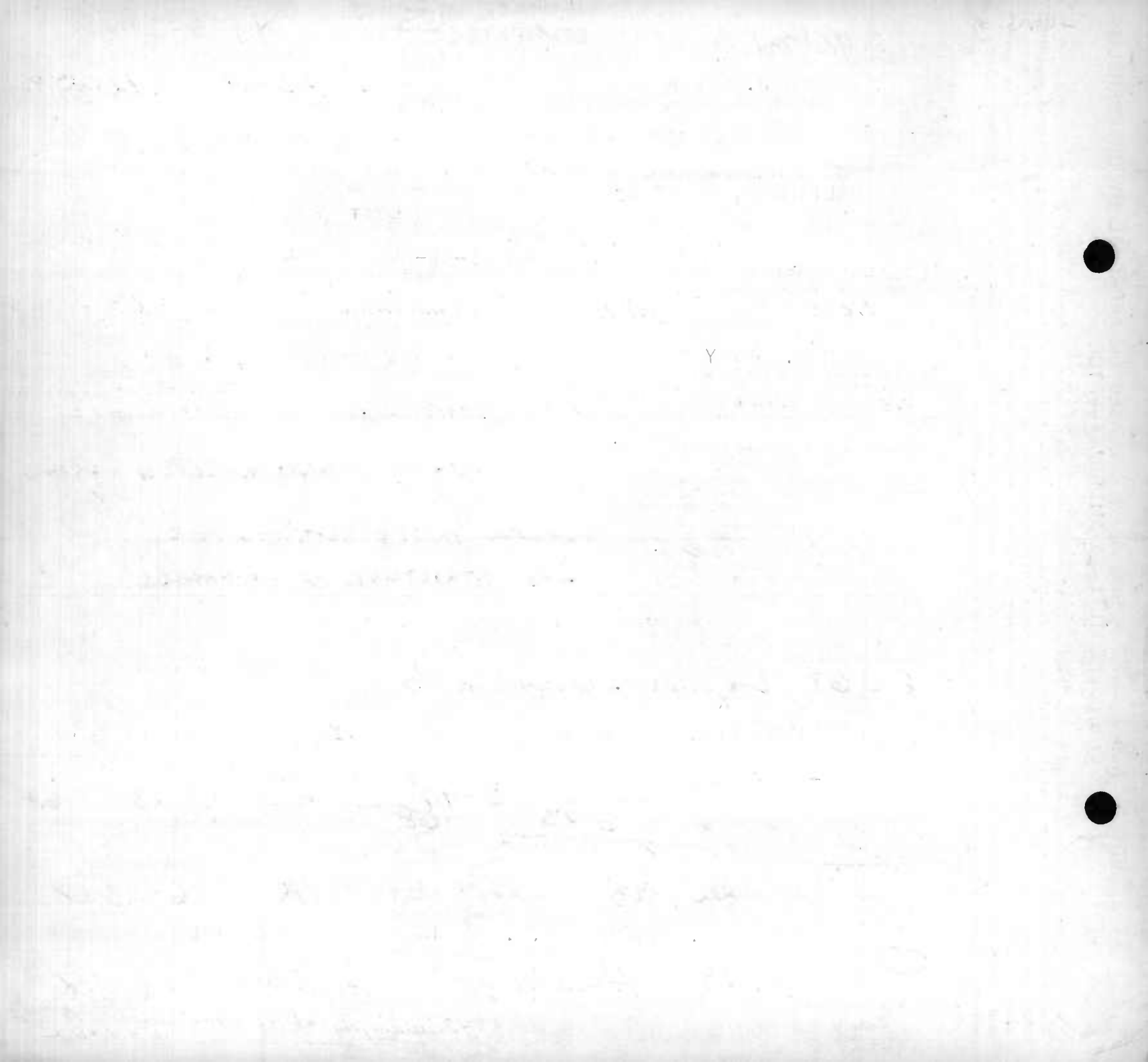
ADDRESS
901 S. Conkling St.
Balto., 21224, Md.

Robert M. Kline

Charles E. Kline

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <i>Pa. Geo. Md.</i> 68- 6539				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <i>68- 6539</i>	
1. NAME OF DECEASED (Type or Print) NORMA J. BROWN				2. DATE AND HOUR OF DEATH 6-23-68 12:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY PRINCE GEORGE			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN FAIRMOUNT HEIGHTS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1111 62st AVE				<i>66-00</i>			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-64		9. AGE (In years last birthday) 4	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NORMEN E. SAVOY				14. MOTHER'S MAIDEN NAME VEREE HARROD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Veree Brown		ADDRESS Fairmount Hgts Rd 1111-62nd AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GRAM NEGATIVE SEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. COLON INTERPOSITION FOR LYE STRICTURE OF ESOPHAGUS				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GRAM NEGATIVE SEPSIS 12 MRS (B) COLON INTERPOSITION FOR (C) LYE STRICTURE OF ESOPHAGUS			
19A. DATE OF OPERATION 6-3-68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LYE STRICTURE OF ESOPHAGUS		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH DRANO INGESTION				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1111 62ST AVE, FAIRMOUNT HEIGHTS	
21D. TIME OF INJURY (APPROX.) 5- -67				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 2		21F. HOW DID INJURY OCCUR? DRANK DRANO AT HOME	
22. I certify that (I) (this hospital) attended the deceased from 3-17 19 6 to 6-23 19 68 , that (I) (we) last saw the deceased alive on 6-23 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sherman G. Souther, M.D.</i>				23B. DATE SIGNED 6-23-68		23C. PHYSICIAN'S NAME (Type) SHERMAN G. SOUTHER M.D.	
23D. ADDRESS JOHNS HOPKINS HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) 7-1-68			
24B. DATE 7-1-68				24C. NAME OF CEMETERY or CREMATORY Harmony		24D. LOCATION (City, town, or county) (State) Highland Park Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968				25B. NAME OF REGISTRAR <i>John B. E. Johnson</i>		25C. FUNERAL DIRECTOR <i>H. J. Washington + Sons</i>	
				ADDRESS 4925 Denne Ave NE Wash. D.C.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
68- 6540				68- 6540	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
WILSON, ALBERT				6-22-68 8:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				A. STATE	
				B. COUNTY	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
421 N. CHAPEL STREET					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday)
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6-6-20	48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Pitt N.C.	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
Frank Wilson				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
No				245-12-0932	
17. INFORMANT				ADDRESS	
Mary Wilson				421 Chapel.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CVA	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:	
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6/22 19 68 to 6/22 19 68, that (1) (we) lost saw the deceased alive on 8:20 AM 6/22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Allen B Kaiser MD				6/22	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Allen B Kaiser, MD				JHH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/27/68		Mt. Auburn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore, Md.		Morton & Dyett		F.H. 1701 Laurens	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 26 1968		Robert E. Taylor		Morton & Dyett	

Frank Wilson

For A.C.

at first thing

General of the M. D. B. B.

1944

March - April 1944

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 6541

BIRTH NO.		1. NAME OF DECEASED (Type or Print) BUTTS SARAH		2. DATE AND HOUR OF DEATH 6/24/68 1:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-06			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1908 9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Franklin, VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Handshaw		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rev. Robt. C. Butts ADDRESS 2802 Walbrook Ave.	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) RECURRENT CARCINOMA OF CERVIX		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
171X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-14-1968 19 to 6-24-1968 , that (1) (we) last saw the deceased alive on 6-24-68 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE P. P. Joshi MD		23B. DATE SIGNED 6-24-68		23C. PHYSICIAN'S NAME (Type) P. P. JOSHI MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/28/68		24C. NAME OF CEMETERY or CREMATORY Franklin Cem.	
24D. LOCATION (City, town, or county) Suffolk, VA.		24E. NAME OF REGISTRAR Morton J. Yett		24F. FUNERAL DIRECTOR ADDRESS 1701 LAURENS ST.	

Page 1 of 1
Date: 10/10/10
Author: J. L. L. L.

R-320

68- 6542 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6542

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAURICE ROOTS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968 9:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001516 Madison Avenue		3. DATE PRONOUNCED DEAD Month Day Year June 23, 1968 9:45 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4-27-35		10. AGE (In years last birthday) 33	
11. BIRTHPLACE (State or foreign country) Portsmouth, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNK.		17. SOCIAL SECURITY NO.	
18. INFORMANT Fisher F. H. Portsmouth, Va.		ADDRESS	
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTecedent CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Fatty Alteration of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68	
24C. NAME of CEMETERY or CREMATORY Lincoln Memorial		24D. LOCATION (City, town, or county) (State) Portsmouth VA.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Fadden	
25C. FUNERAL DIRECTOR MORTON & Dyett		ADDRESS 1701 LAURENS	

29
Lynch in Hospital
Boston - 1941

68- 6543

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6543

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Pauline HILL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968		Hour 12:50 P.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1968		Hour 12:50 P.
6. SEX Female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 3-30-1924		10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Jackson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress
15. MOTHER'S MAIDEN NAME Fannie L Snowden		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-18-8694
18. INFORMANT Thomas D. Hill, Jr		19. ADDRESS Frederick, Md		20. CAUSE OF DEATH Subarachnoid Hemorrhage
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ruptured Aneurysm circle of Willis		22. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ruptured Aneurysm circle of Willis		23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		25. DATE OF OPERATION 2		26. CONDITION FOR WHICH OPERATION WAS PERFORMED
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
30. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) 22		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL EXAMINER'S SIGNATURE Ronald N. Kornblum, M.D.		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>
36. DATE REC'D BY HEALTH DEPT. JUN 26 1968		37. NAME OF REGISTRAR Robert E. Fairburn		38. FUNERAL DIRECTOR C.E. Hicks, 111 263 W. Patrick St
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 6-25-1968		41. NAME OF CEMETERY or CREMATORY Fairview
42. LOCATION (City, town, or county) (State) Frederick Maryland		43. DATE June 23, 1968		44. ADDRESS Frederick, Md

X

Michigan State

3-27-1944

Franklin D. Roosevelt

and his family

215-13-1004

Washington, D.C.

Dear Mr. Roosevelt:

[Handwritten signature]

5-22-1968

U.S. House of Representatives

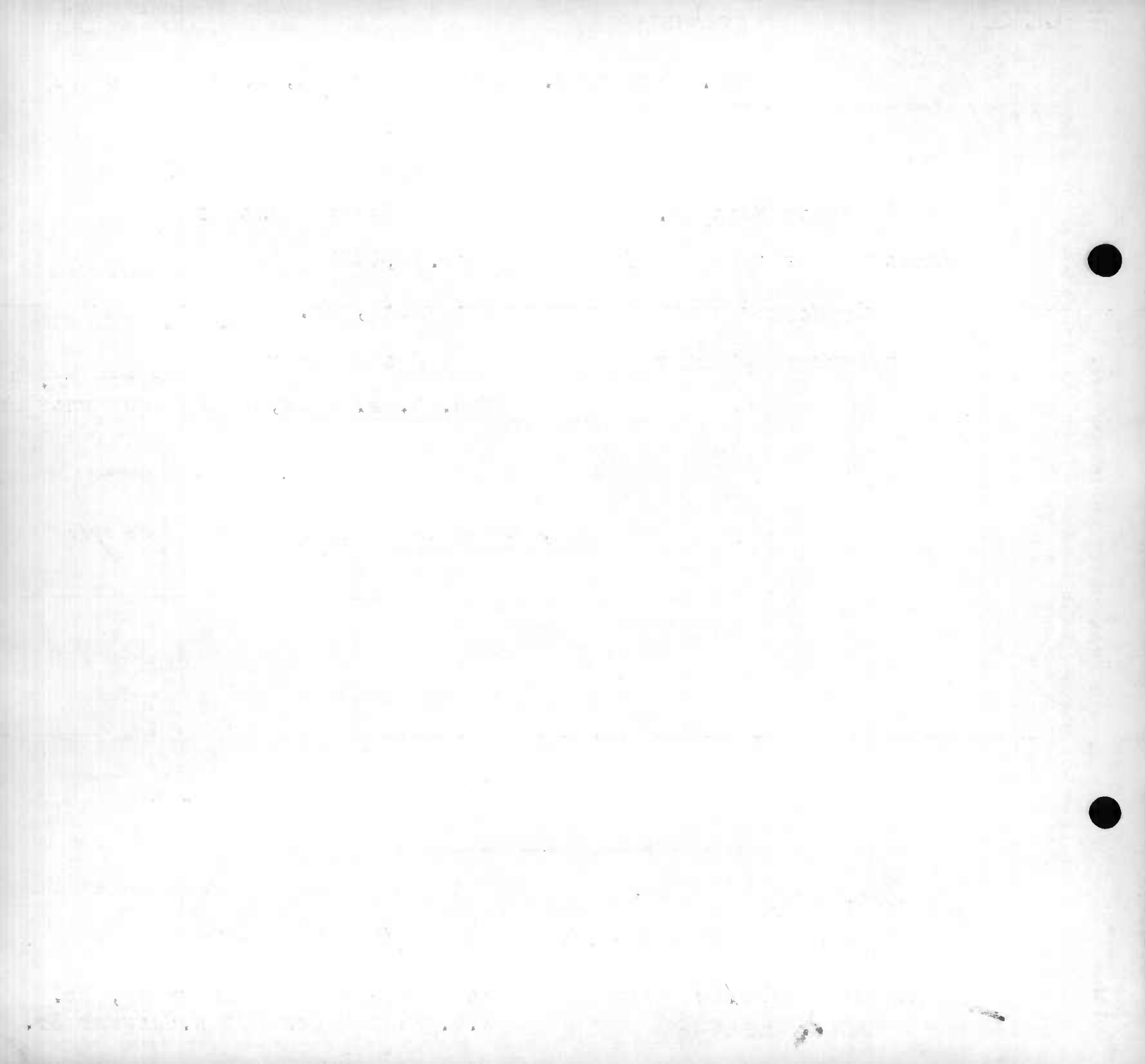
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6544 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

68- 6544 REG. NO.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MRS. KATHRYN H. FRANZ		JUNE 22, 1968 900 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
00 4327 MARBLE HALL RD.				MARYLAND	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				4327 MARBLE HALL RD	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT. 28, 1897	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
AT HOME			BALTIMORE, MD.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FREDERICK DEWBERRY			JULIA DACEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT ADDRESS		
			MRS. W. A. PEAT, JR 910 SOUTHERLY RD TOWSON MD. 4		
18. 410.7 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Myocardial infarction minutes	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Atherosclerotic heart disease		25 years	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 1947 to Jun 22, 1968, that (I) (we) last saw the deceased alive on Jun 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frederick J. Vollmer				Jun 24, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
FREDERICK J VOLLMER MD				6100 York Rd Baltimore Md 21212	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		6/25/68		NEW CATHEDRAL CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 26 1968		Robert E. Farber		H.W. MEARS & SON 805 N. CALVERT ST.	



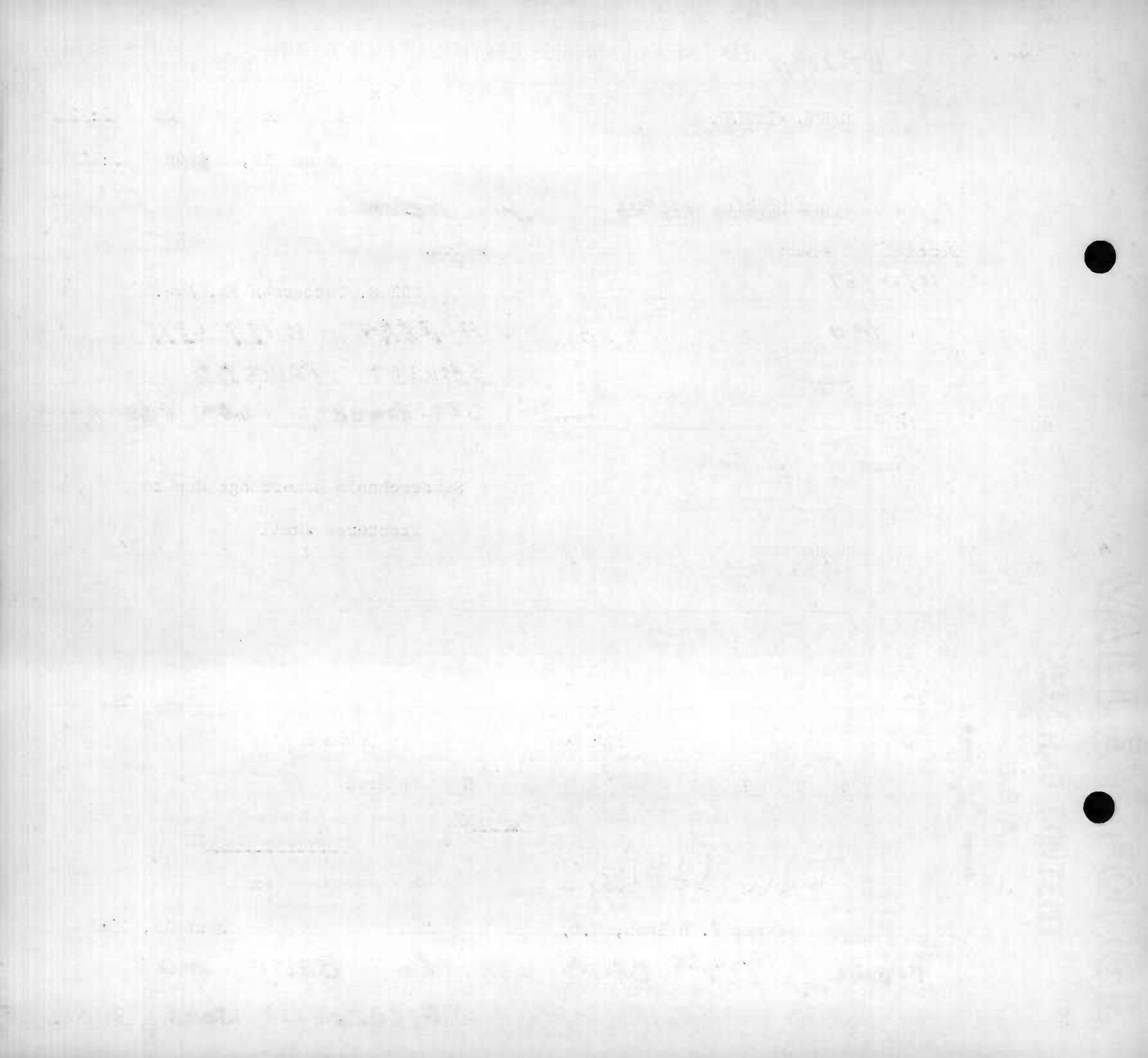
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6545

BIRTH NO. 67-20748

1. NAME OF DECEASED (Type or Print) CAROL WITTLER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 18 68 5:12 p.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 18, 1968 5:12 p.M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1-05	
7. RACE White		C. CITY OR TOWN Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10/12/67		E. STREET AND NUMBER 222 S. Patterson Pk. Ave.	
10. AGE (In years lost birthday) 8		11. BIRTHPLACE (State or foreign country) MO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALBERT WITTLER	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME SHIRLEY POWERS	
14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS GEO. POWERS 604 FRANKLIN	
19. CAUSE OF DEATH E988X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Subarachnoid hemorrhage due to fractured skull		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown		22D. TIME OF INJURY (APPROX.) Month Day Year Hour Min. ? ? ? ? m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 10/24/68	
24C. NAME OF CEMETERY or CREMATORY BALTO. NAT. CEM		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR J.G. CONNELLY SONS		25D. ADDRESS 300 MACE	



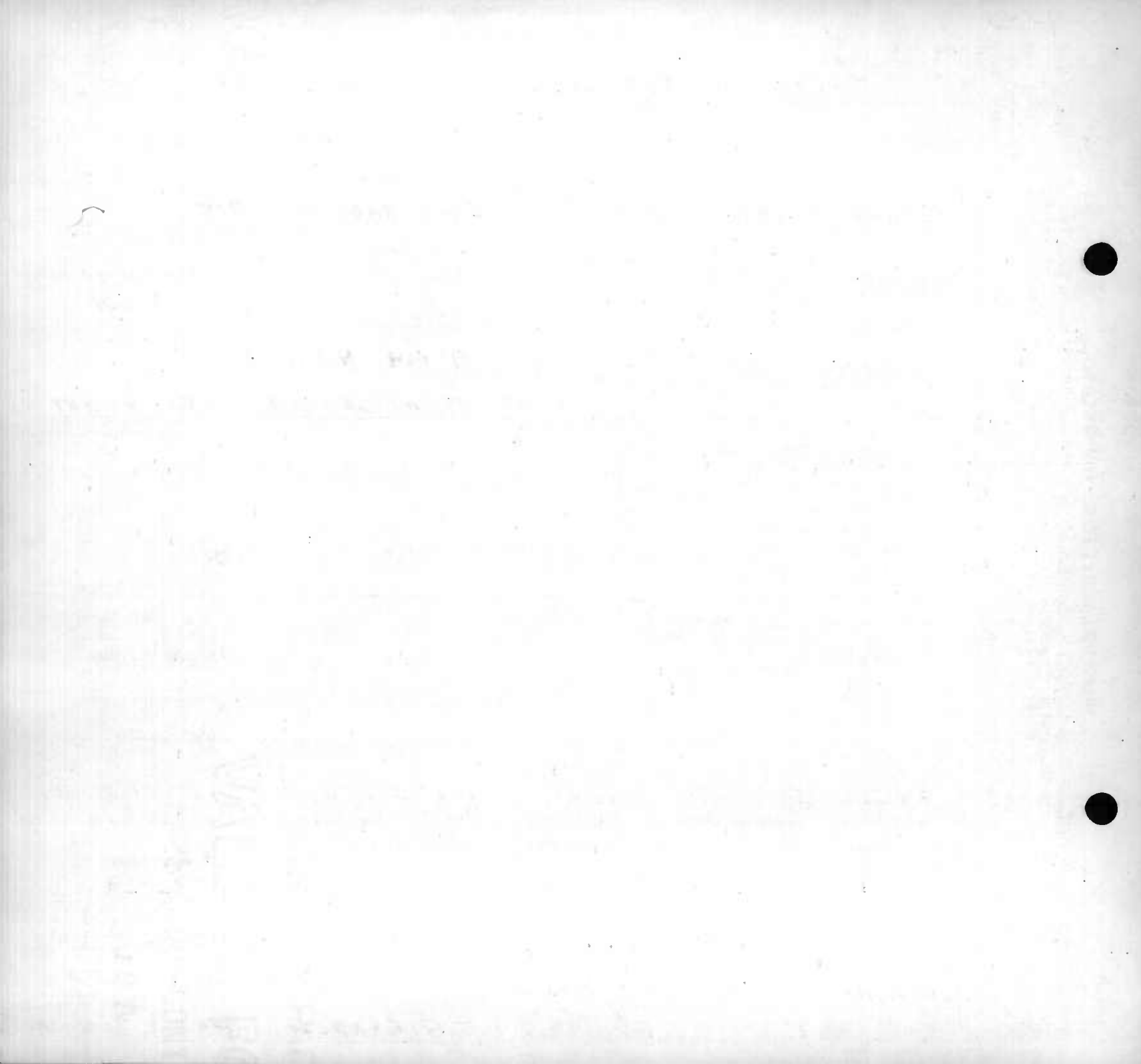
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6546 CERTIFICATE OF DEATH

REG. NO. 68- 6546

BIRTH NO.		1. NAME OF DECEASED (Type or Print) AUDREY M. SEAWELL		2. DATE AND HOUR OF DEATH JUNE 20 1968 ^{11:53} P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSP			C. CITY OR TOWN ROSEDALE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5907 RADECKE AVE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/07	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA	
13. FATHER'S NAME WILLIAM DUNLAP SEAWELL			14. MOTHER'S MAIDEN NAME ALMA HARDER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 4-44-3208		17. INFORMANT TRENT SEAWELL ADDRESS 5531 WHITBY RD	
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Artery Disease			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive arteriosclerotic		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II			(C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-20-1967 to 1-30-1968 , that (I) (we) last saw the deceased alive on 1-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juri Hinno, M.D.				23B. DATE SIGNED 6-22-68	
23C. PHYSICIAN'S NAME (Type) Juri Hinno, M.D.				23D. ADDRESS 5002 Frankford Avenue Baltimore, Maryland 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/24/68		24C. NAME OF CEMETERY or CREMATORY DAK LAWN	
24D. LOCATION BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR J. G. CONNELLY		25C. FUNERAL DIRECTOR SONS ADDRESS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68- 6547
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary E. Norris		
2. DATE AND HOUR OF DEATH 6/18/68 3⁵⁰ A. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 25-04		
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX ♀ 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/93 9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Reilly		
14. MOTHER'S MAIDEN NAME Katie I. Stamp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 212 05 9890		17. INFORMANT chant.		
18. 2509 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac arrest.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) MI DUE TO, OR AS A CONSEQUENCE OF: (C) DM		
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		?		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/10/68 19 to 6/18/68 19, that (I) (we) last saw the deceased alive on 6/18/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ralph D. Raymond MD		23B. DATE SIGNED 6/18/68		23C. PHYSICIAN'S NAME (Type) Ralph D. REYMOND
23D. ADDRESS Maryland Gen. Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-22-68		24C. NAME OF CEMETERY or CREMATORY Zion Evangelical Mth. Ch.
24D. LOCATION (City, town, or county) (State) Balto., Md.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm. J. Freeman & Son		25C. FUNERAL DIRECTOR ADDRESS Balto., Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
CERTIFICATE OF DEATH				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS BLANCHE STENCEL		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 6/21/68 545 P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION MD. GEN'L HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 13-01		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F 6. RACE W.		E. STREET AND NUMBER 2401 EUTAW PL.		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/83 9. AGE (In years 35 last birthday) If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME JOHN J. SCHREIVER		
14. MOTHER'S MAIDEN NAME SARA TRACEY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT MISS AUSTIN ADDRESS LAKE DR. NUTTING HONE 2401 EUTAW PL. BALTO.		
18. 563.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Dehydration		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Diabetes		
		(C) R. lobe Pneumonia		
19. 572.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ASCVD		
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 68 to 6/21 19 68 , that (I) (we) lost saw the deceased alive on 6/21 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE F. J. ZORICK M.D. DEGREE M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/21/68.
23C. PHYSICIAN'S NAME (Type) F. J. ZORICK M.D. DEGREE M.D.				23D. ADDRESS MD. GEN'L HOSP BALTO
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	6/24/68	Western Cem.	Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
JUN 26 1968	Robert E. Feltner	Wm. J. Trichner & Son	Balto., Md.	

FUNERAL DIRECTOR: IMPORTANT

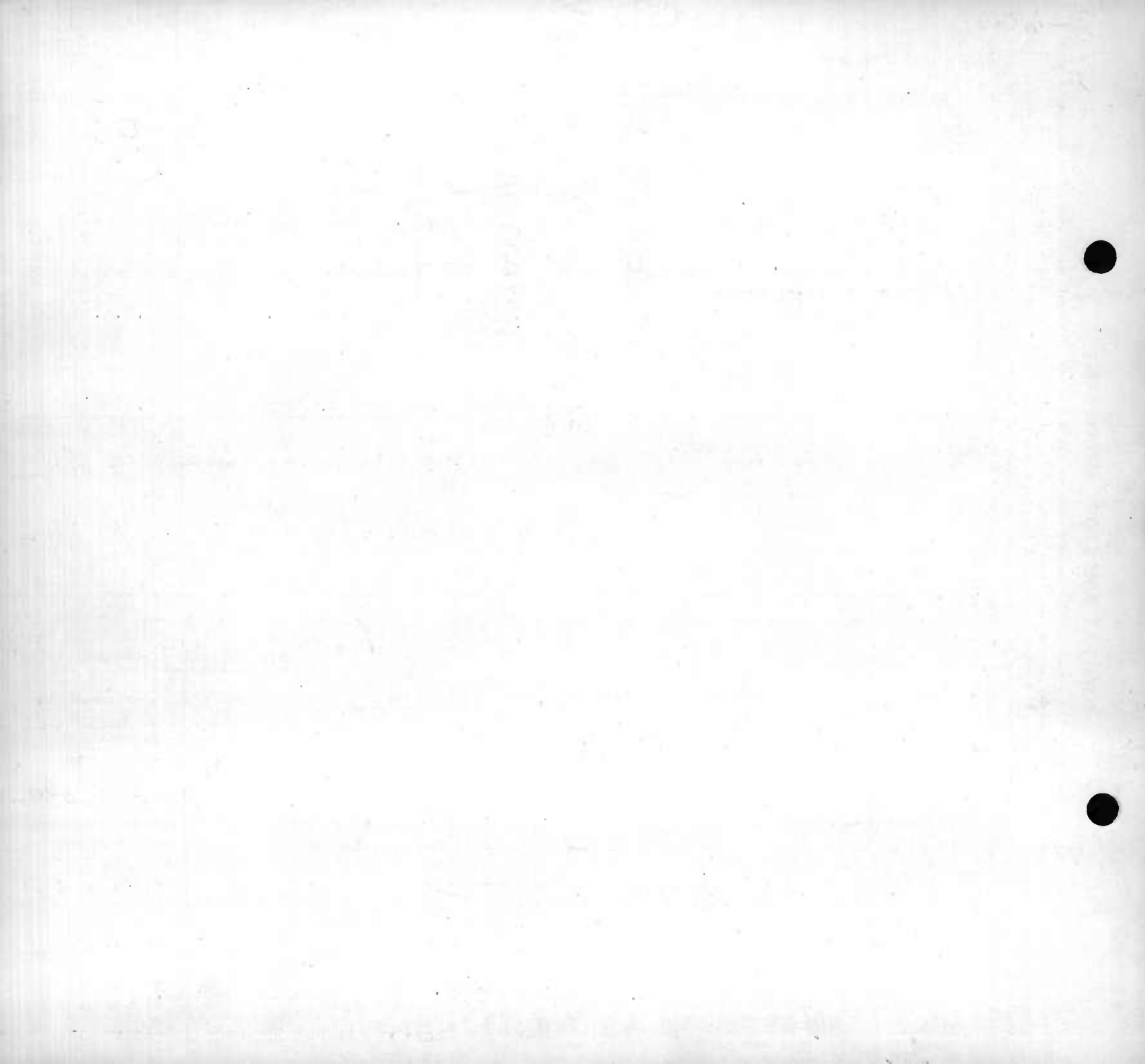
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6549

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Henry Suhre</u>		2. DATE AND HOUR OF DEATH <u>6-22-1968</u> <u>1</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> 8. COUNTY <u>S-03</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2535 E. Biddle Street 21213</u>		C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Cau.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlem Steel Co.</u>		8. DATE OF BIRTH <u>12-6-1880</u>	
13. FATHER'S NAME <u>John Suhre</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Durling</u>		9. AGE (In years last birthday) <u>87</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-8925</u>		11. BIRTHPLACE (State or foreign country) <u>New Baltimore, Penna.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHOPNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>422.1 II</u>		(B) <u>Anteriosclerotic C.V.D.</u>		<u>5 yrs</u>	
		(C) _____			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>67</u> to <u>6/22</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/17</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Isadore K. Grossman</u>		23B. DATE SIGNED <u>6/24/68</u>		23C. PHYSICIAN'S NAME (Type) <u>Isadore K Grossman</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-25-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Joseph's Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR <u>Cassahn Funeral Home</u>	
				24D. LOCATION (City, town, or county) (State) <u>Fullerton Balto. Md</u>	
				ADDRESS <u>7401 Belair Road</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6550

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 6550

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HARMAN, Lester J.

2. DATE AND HOUR OF DEATH

June 23, 1968 11 40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A, STATE

B, COUNTY

Maryland Baltimore

C, CITY OR TOWN

Baltimore

D, INSIDE CITY LIMITS?

YES ☐NO ☐

E, STREET AND NUMBER

4418 Clyderdale Ave.

5, SEX

Male

6, RACE

White

7, MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8, DATE OF BIRTH

7/31/13

9, AGE (In years
lost birthday)

54

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A, USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B, KIND OF BUSINESS OR INDUSTRY

Home Repairs

11, BIRTHPLACE (State or foreign country)

Md

12, CITIZEN OF WHAT COUNTRY?

USA

13, FATHER'S NAME

Howard Harman

14, MOTHER'S MAIDEN NAME

Cora Guyman Geiman

15, Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16, SOCIAL
SECURITY NO.

213 03 4283

17, INFORMANT

Thelma L Harman 4418 Clydesdale Ave

ADDRESS

18, 3-21-81

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

gt bleeding

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

24 hrs

(B) DUE TO, OR AS A CONSEQUENCE OF:

Hepatic failure, peptic ulcer

7 2 months

(C)

Biliary cirrhosis

7 3 years

5-8-10 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Sclerosing cholangitis

7 3 years

19A, DATE OF OPERATION

6/11/68

19B, CONDITION FOR WHICH OPERATION
WAS PERFORMED

obstructive jaundice

20A, AUTOPSY? (Yes or No)

Yes

20B, IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A, ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B, PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C, WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D, TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E, INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F, HOW DID INJURY OCCUR?

22, I certify that (I) (this hospital) attended the deceased from 6/19 1968 to 6/23 1968,
that (I) (we) last saw the deceased alive on 6/23 1968 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A, SIGNATURE

Timothy J. Gardner

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B, DATE SIGNED

6/23/68

23C, PHYSICIAN'S
NAME (Type)

Dr. Timothy J. Gardner

DEGREE

23D, ADDRESS

The Johns Hopkins Hospital

24A, BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B, DATE

6-27-68

24C, NAME OF CEMETERY or CREMATORY

Druid Ridge Cem

24D, LOCATION

(City, town, or county)

(State)

P. Kesville Bldg Co Md

25A, DATE REC'D BY HEALTH DEPT.

JUN 26 1968

25B, NAME OF REGISTRAR

Robert E. Finkbeiner

25C, FUNERAL DIRECTOR

Borgess Funeral Home

ADDRESS

Baltimore Md

FUNERAL DIRECTOR: IMPORTANT

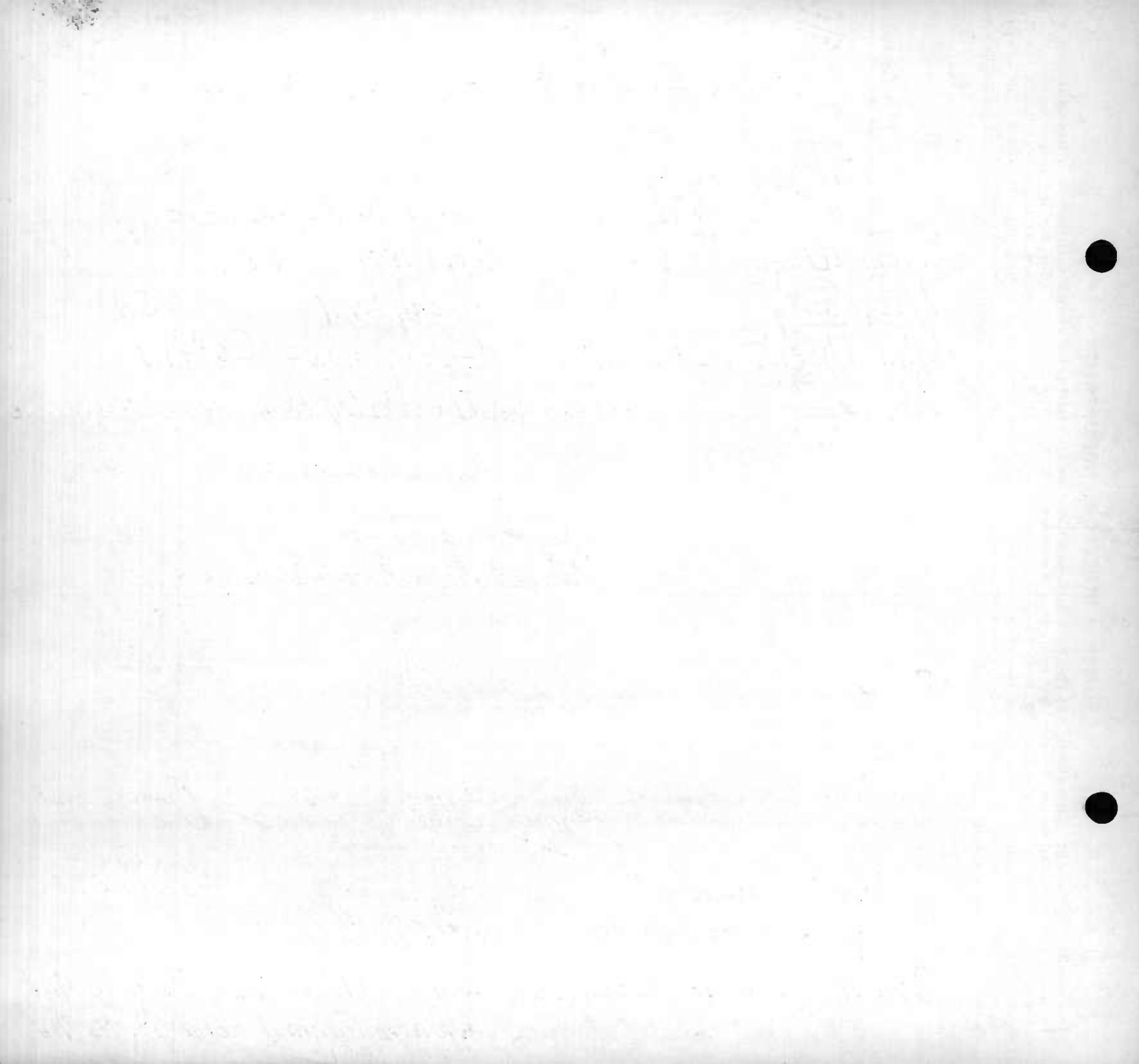
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6551

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6551

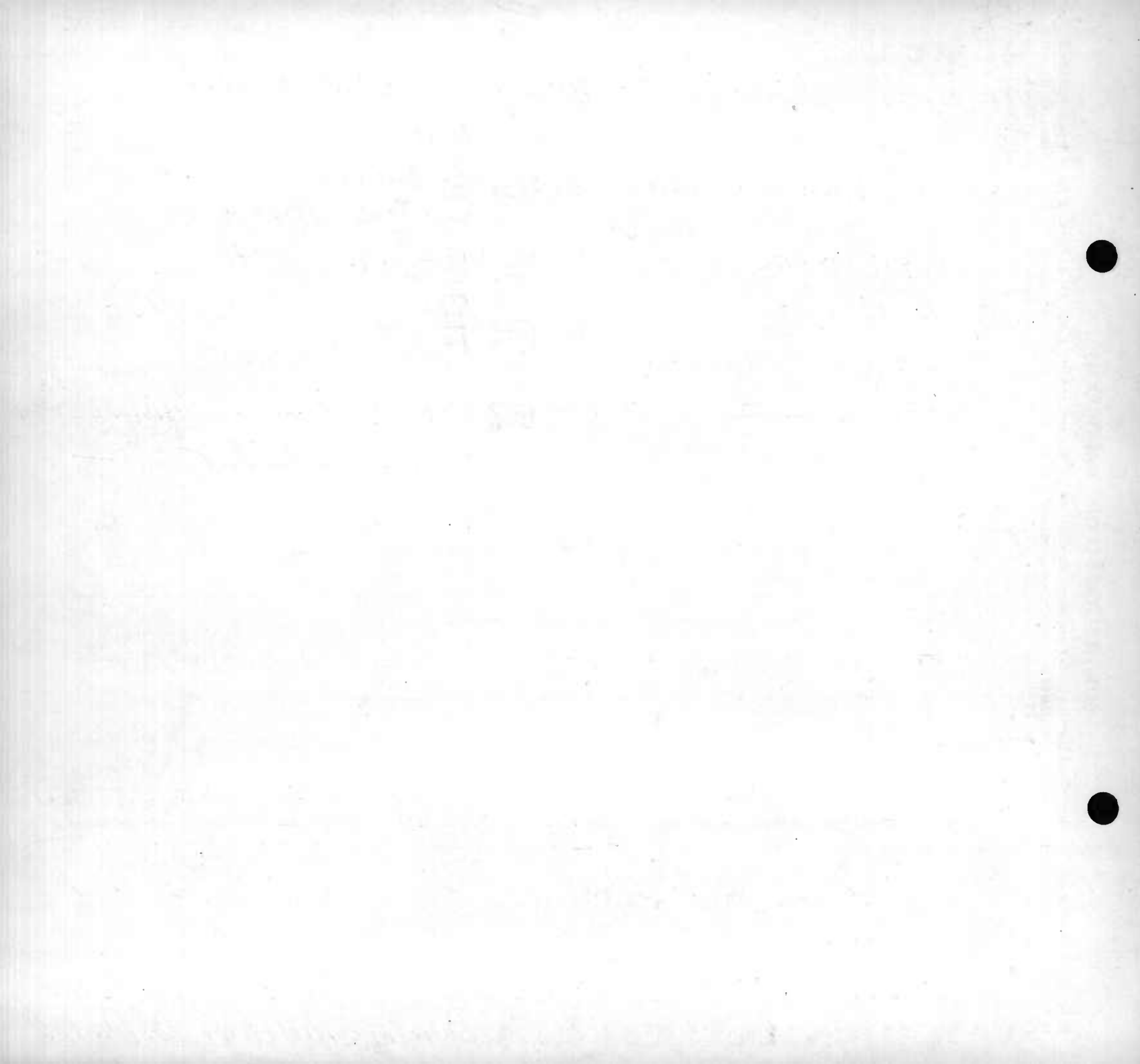
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hester E. Bartholomee		June 24 1968 7 ¹⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 The Wesley Home 2211 W Rogers Ave				Md 27-15	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				City YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				2211 W Rogers Ave	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	July 7 1879	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Thomas Hubbard			Georgianna Coffin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		21722 2316D		The Wesley Home 2211 W Rogers Ave	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Myocardial infarction	
				(B) Coronary occlusion	
				DUE TO, OR AS A CONSEQUENCE OF:	
				Arteriosclerotic cardiovascular disease	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 23 June 1968 to 24 June 1968, that (I) (we) last saw the deceased alive on 23 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John W Barnaby				25 June 68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN W BARNABY		1531 E North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	6-27-68	Woodlawn Cem	Woodlawn Bldg Co Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 26 1968	Robert E. Fairbank	Burger Funeral Home		Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6552
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward J Finnnessy</i>		2. DATE AND HOUR OF DEATH <i>June 21 1968</i> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>12-06</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2715 N Howard St</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 23 1893</i>	9. AGE (In years last birthday) <i>74</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bartender</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>James Finnnessy</i>		
14. MOTHER'S MAIDEN NAME <i>Kate Rummel</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>214 031857</i>		17. INFORMANT <i>Edward J Finnnessy Jr</i> ADDRESS <i>PA 12 New Freedom</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.21</i> (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Accident</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>HASCD</i>		
(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>443X II</i>				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>January 19 66</i> to <i>February 19 68</i> , that (I) (we) last saw the deceased alive on <i>June 21 19 68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (WE) (did) (did not) view the body after death. <i>Spoke to medical Examiner's office & released.</i>				
23A. SIGNATURE <i>Herman Brecher, M.D.</i>		23B. DATE SIGNED <i>6/24/68</i>		23C. PHYSICIAN'S NAME (Type) <i>HERMAN BRECHER, M.D.</i>
23D. ADDRESS <i>443 E. 25th St.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-25-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn Cem</i>
24D. LOCATION (City, town, or county) (State) <i>Woodlawn Bk Co Md</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR <i>Burger Funeral Home Bk to Md</i>
25D. ADDRESS <i>134 N. ...</i>				



FUNERAL DIRECTOR: IMPORTANT

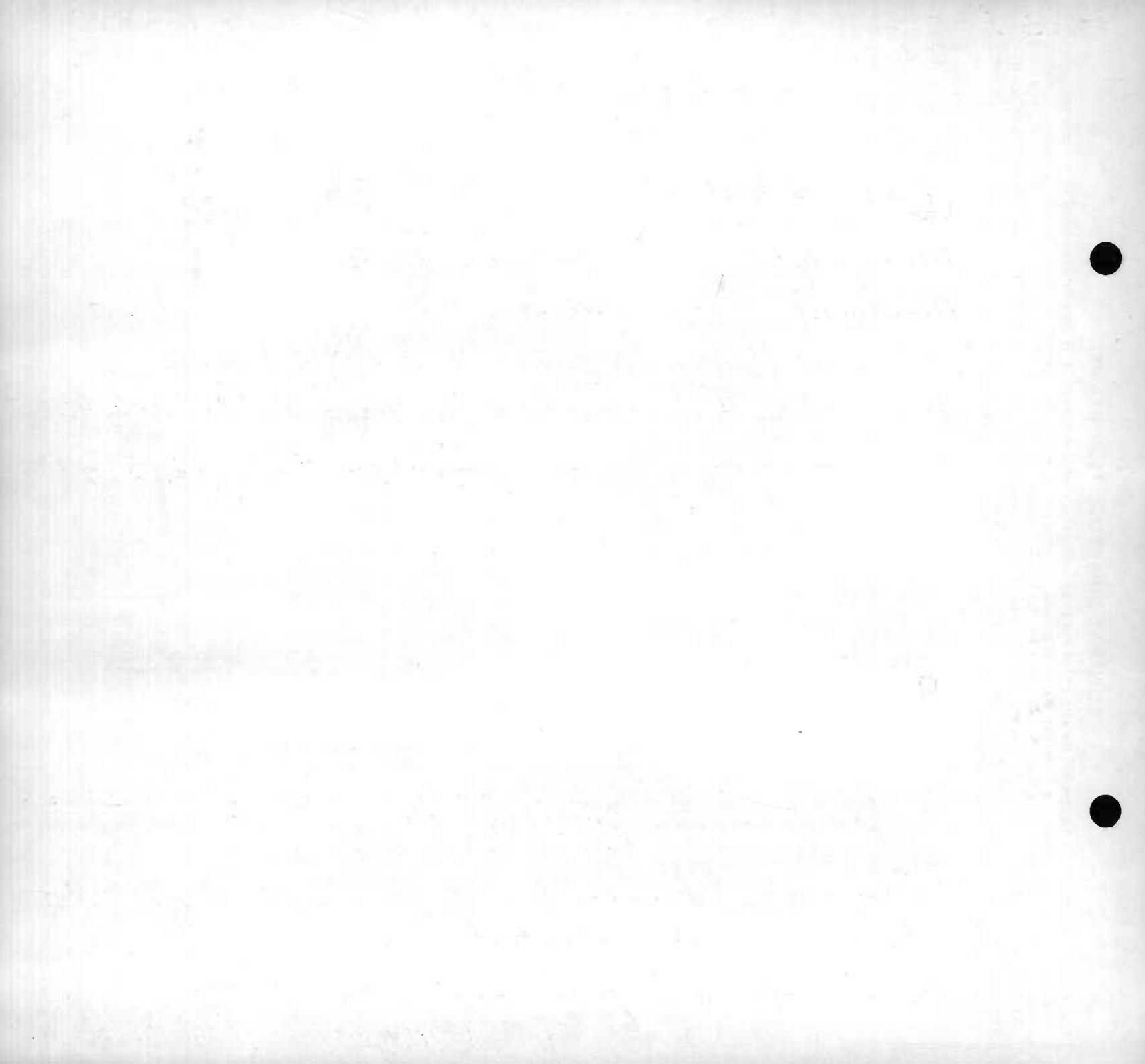
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6553

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 6553

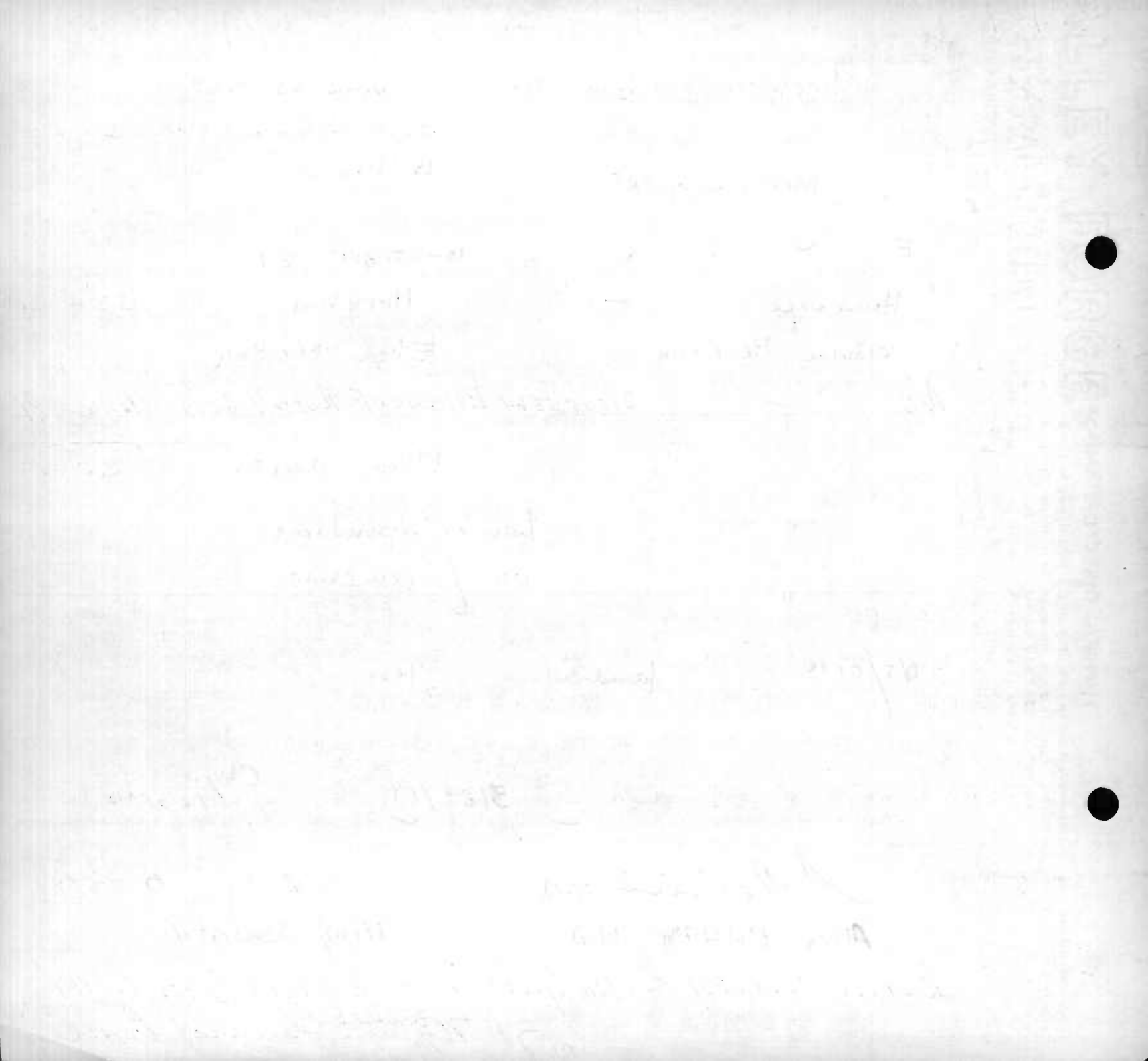
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Christian W. Snyder		2. DATE AND HOUR OF DEATH June 21 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md B. COUNTY 13-08			
FULL NAME OF HOSPITAL OR INSTITUTION 1301 W 41st St		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1301 W 41st St					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 4 1896	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elect Co		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Adelbert Henry Snyder			
14. MOTHER'S MAIDEN NAME Marie Schimpf		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II			
16. SOCIAL SECURITY NO. 212166906		17. INFORMANT Martha I Snyder			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Anterior & IC CVD 5 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1960 to June 21 1968 , that (I) (we) last saw the deceased alive on June 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward L. Glassman MD		23B. DATE SIGNED 6/24/68		23C. PHYSICIAN'S NAME (Type) EDWARD L. GLASSMAN MD	
23D. ADDRESS Baltimore		23E. FUNERAL DIRECTOR Burgess Funeral Home			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 25 Jun 68		24C. NAME of CEMETERY or CREMATORY B21 to National	
24D. LOCATION (City, town, or county) (State) B21 to Md		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. ADDRESS Burgess Funeral Home B21 to Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68- 6554
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Klinefelter, Mrs. Lela M.		June 23 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
37 Mercy Hospital			6015 Altament place Balto #10		
5. SEX F			6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH
					10-25-1920
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
Housewife			-		87
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Maryland			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William McCann			Eliza McRae		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or No)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			21505 5864		Ellenora F Russell
18. CAUSE OF DEATH			ADDRESS		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			6015 Altament Pl		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES			2 weeks		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE		
			DUE TO, OR AS A CONSEQUENCE OF:		
			Illness. ascites		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			former splenitis.		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Ca of Pancreas		
157X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8/5/61		Jaundiced.		Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		Chair	
22. I certify that (I) (this hospital) attended the deceased from 5/22/68 19 to 8/23/68 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
A. Rahimi M.D.				6/23/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Abbas RAHIMI M.D.				Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Jun 26 68		Poplar Grove Cem	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 26 1968		Robert E. Starnes		F. J. BURGE	
				Address	
				4014 E. Federal Ave. Baltimore	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6555 CERTIFICATE OF DEATH

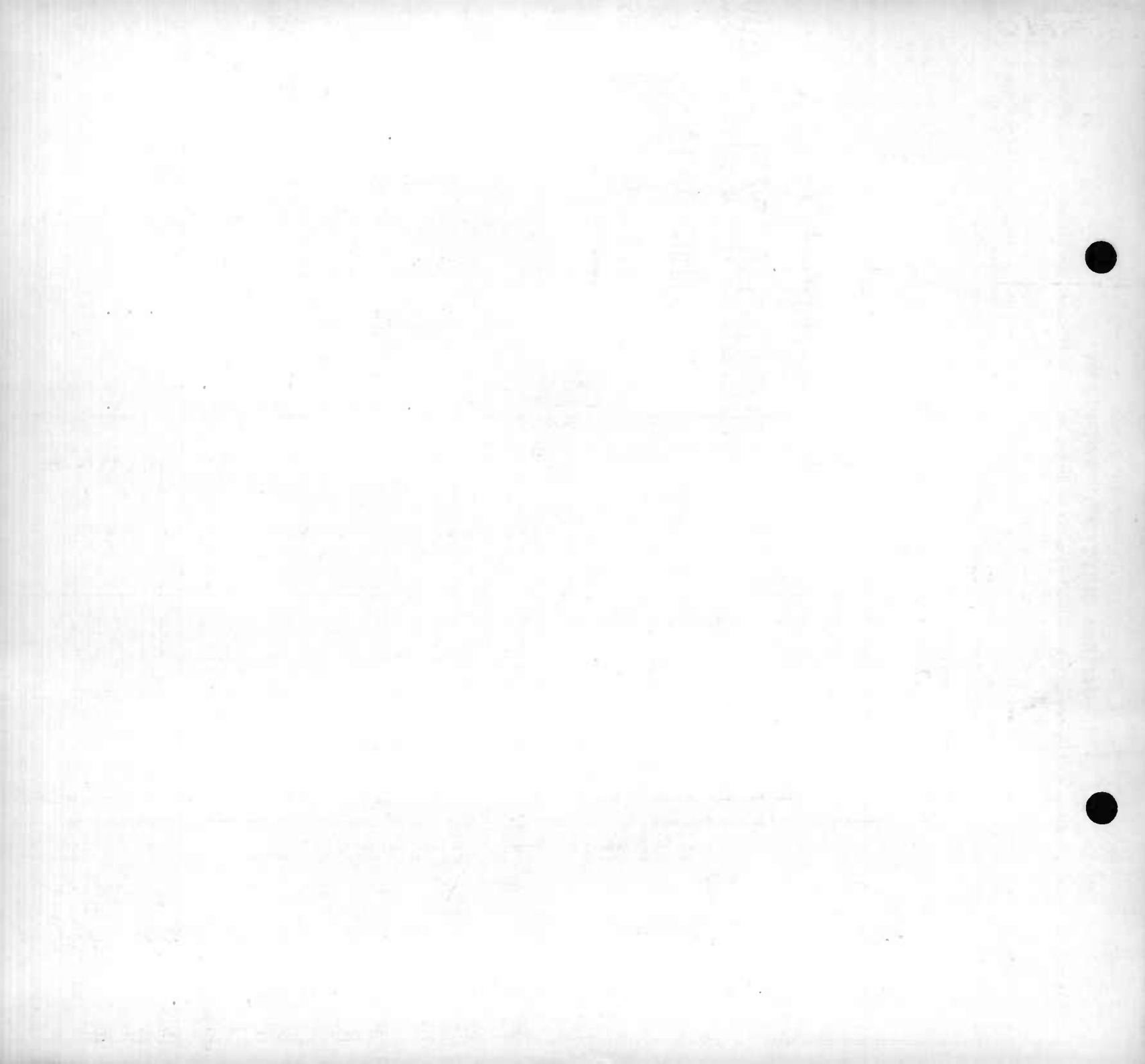
REG. NO. 68- 6555

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Goldie May Kirby		2. DATE AND HOUR OF DEATH 6-23-68 2 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 12-06			
FULL NAME OF HOSPITAL OR INSTITUTION 00 255 W 31st St		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 255 W 31st St	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 21 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: (If Under 24 Hrs. Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nanitress		10B. KIND OF BUSINESS OR INDUSTRY City Buildings		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Millard B Krout		14. MOTHER'S MAIDEN NAME Laura E Bollinger	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 21818 0661		17. INFORMANT Gordon J. Kirby	
18. 4-10-71		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarct.		Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Arterio insufficiency		several years?	
		(C) Seriously. Confined to bed		6 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr 1968 to 6-23-68 19 22 that (I) was last saw the deceased alive on June 19 22 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE Z Vance Hooper		23B. DATE SIGNED 6-24-68		23C. PHYSICIAN'S NAME (Type) Z. VANCE HOOPER, M. D.	
23D. ADDRESS 3334 Ellerslie Ave		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-68	
24C. NAME OF CEMETERY or CREMATORY Cathedral Cem		24D. LOCATION Baltimore Md		24E. DATE REC'D BY HEALTH DEPT. JUN 26 1968	
25A. NAME OF REGISTRAR W. B. E. Taylor		25B. FUNERAL DIRECTOR Burger Funeral Home Btlto Md		25C. ADDRESS Bu Nova Bldg	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6556	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Anna Koerber	
2. DATE AND HOUR OF DEATH 6-22-1968				M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8. COUNTY 27-44	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3607 Mary Avenue 21206				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3607 Mary Avenue 21206					
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1870	9. AGE (In years last birthday) 97	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Adam Wiegand			
14. MOTHER'S MAIDEN NAME Eva Meister		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 220-46-8371		17. INFORMANT ADDRESS Hyattsville, Md. 21781 Rose A. Koerber 4410 Pglethorpe St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante coronary thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: minute ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis yrs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/31 1950 to 6-22 1968, that (I) (we) last saw the deceased alive on 6-18 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MARION FRIEDMAN, MD				23B. DATE SIGNED 6/24/68	
23C. PHYSICIAN'S NAME (Type) MARION FRIEDMAN, MD				23D. ADDRESS 5211 HARFORD ROAD BALTO MD 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-25-68		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Co. M		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR Robert E. Friedman		25C. FUNERAL DIRECTOR Massachusetts Funeral Home 7401 Belair Road			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital; (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6557 CERTIFICATE OF DEATH

REG. NO. 68- 6557

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bock, Mary</i>		2. DATE AND HOUR OF DEATH <i>6-23-68 4:25 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>27-19</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>5605 Woodcrest Ave</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-9-07</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John W. Warren</i>			14. MOTHER'S MAIDEN NAME <i>Fannie Fisher</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>195 073776</i>		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Heart failure</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Anemia</i>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>293X II</i>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-17-68</i> to <i>6-23-68</i> that (I) (we) lost saw the deceased alive on <i>6-23-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nat Poole</i>				23B. DATE SIGNED <i>6-23-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Nat Poole</i>				23D. ADDRESS <i>Franklin Square Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/26/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR <i>Loring Byers Chapel</i>			
ADDRESS <i>8728 Liberty Rd. Randallstown Md. 21133</i>					

72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 6558 CERTIFICATE OF DEATH

REG. NO. 68- 6558

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FOWBLE, Mary Lula		2. DATE AND HOUR OF DEATH June 23, 1968		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House In The Pines, Belvedere				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
				C. CITY OR TOWN Timonium		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2116 York Road			
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1886	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank E. Anderson				14. MOTHER'S MAIDEN NAME Cecelia Armstrong			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-32-0488		17. INFORMANT ADDRESS Mr. J. Franklin Fowble, Same as # 4			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease 20 yrs DIABETES MELLITUS							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fr (L) FEMUR							
19A. DATE OF OPERATION 260X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? 2116 York Rd		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 5-29-68		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? falling to bathroom during night			
22. I certify that (I) (this hospital) attended the deceased from 11-7 1964 to 6-21 1968 , that (I) (we) last saw the deceased alive on 6-21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald O. Wood				23B. DATE SIGNED 6/24/68			
23C. PHYSICIAN'S NAME (Type) Donald O. Wood, M.D.				23D. ADDRESS Timonium, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-25-68		24C. NAME OF CEMETERY or CREMATORY Prospect Hill Cemetery		24D. LOCATION (City, town, or county) (State) Towson, Md. 21204	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Rd. 21204			

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General Thomas G. Smith

Adjutant General's Office

Diabetes Mellitus

Dr. J. L. Fennell

Edward W. Oblensky

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6559

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JOSEPH Christian MARR</i>		2. DATE AND HOUR OF DEATH <i>6-24-68 6:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>20-08</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M 73</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sheet Metal Man - Edgewood</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>12-25-1894</i>	
13. FATHER'S NAME <i>CONRAD MARR</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Hugelmeier</i>		9. AGE (In years last birthday) <i>73</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1918</i>		16. SOCIAL SECURITY NO. <i>215-9-49911</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
18. <i>412-24</i>		CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary insufficiency</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hour</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Arterio sclerosis cardiac vascular disease</i>		(C) <i>months</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II Hypernephroma, right kidney</i>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(M)</i> (this hospital) attended the deceased from <i>6/11/1968</i> to <i>6/24/1968</i> , that <i>(M)</i> (we) last saw the deceased alive on <i>6/24/1968</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(M)</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hashemi M.D.</i>		23B. DATE SIGNED <i>6/24/68</i>		23C. PHYSICIAN'S NAME (Type) <i>M.J. Hashemi</i>	
23D. ADDRESS <i>Bon Secours Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 27, 68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>G. Truman Schwab</i>		ADDRESS <i>3512 Frederick Ave, Baltimore, Maryland, 21229</i>	

80-02

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Riley, Loretta F.</i>		2. DATE AND HOUR OF DEATH <i>6/23/68 3:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp.</i>		C. CITY OR TOWN <i>Towson</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>900 Southern Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/30/900</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Elijah Fishpaw</i>		14. MOTHER'S MAIDEN NAME <i>Ida Tipton</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215123200</i>		17. INFORMANT <i>HOSPITAL RECORDS</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cerebral infarct</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anteriosclerotic cardio</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>422.1 II</i>		(B) <i>vascular disease</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/22/68</i> to <i>6/23/68</i> , that (I) (we) last saw the deceased alive on <i>6/23/68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. F. Holcomb M.D.</i>		23B. DATE SIGNED <i>6/23/68</i>		23C. PHYSICIAN'S NAME (Type) <i>H. F. HOLCOMB</i>	
23D. ADDRESS <i>Union Memorial Hosp.</i>		23E. PHYSICIAN'S DEGREE		23F. PHYSICIAN'S ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 26, 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glynmalira Methodist</i>	
24D. LOCATION <i>Baltimore Co. Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. ...</i>	
24G. FUNERAL DIRECTOR <i>Wm. Cook-Brooks</i>		24H. ADDRESS <i>Towson, Towson, Md.</i>		24I. DATE REC'D BY HEALTH DEPT.	

FUNERAL DIRECTOR: IMPORTANT

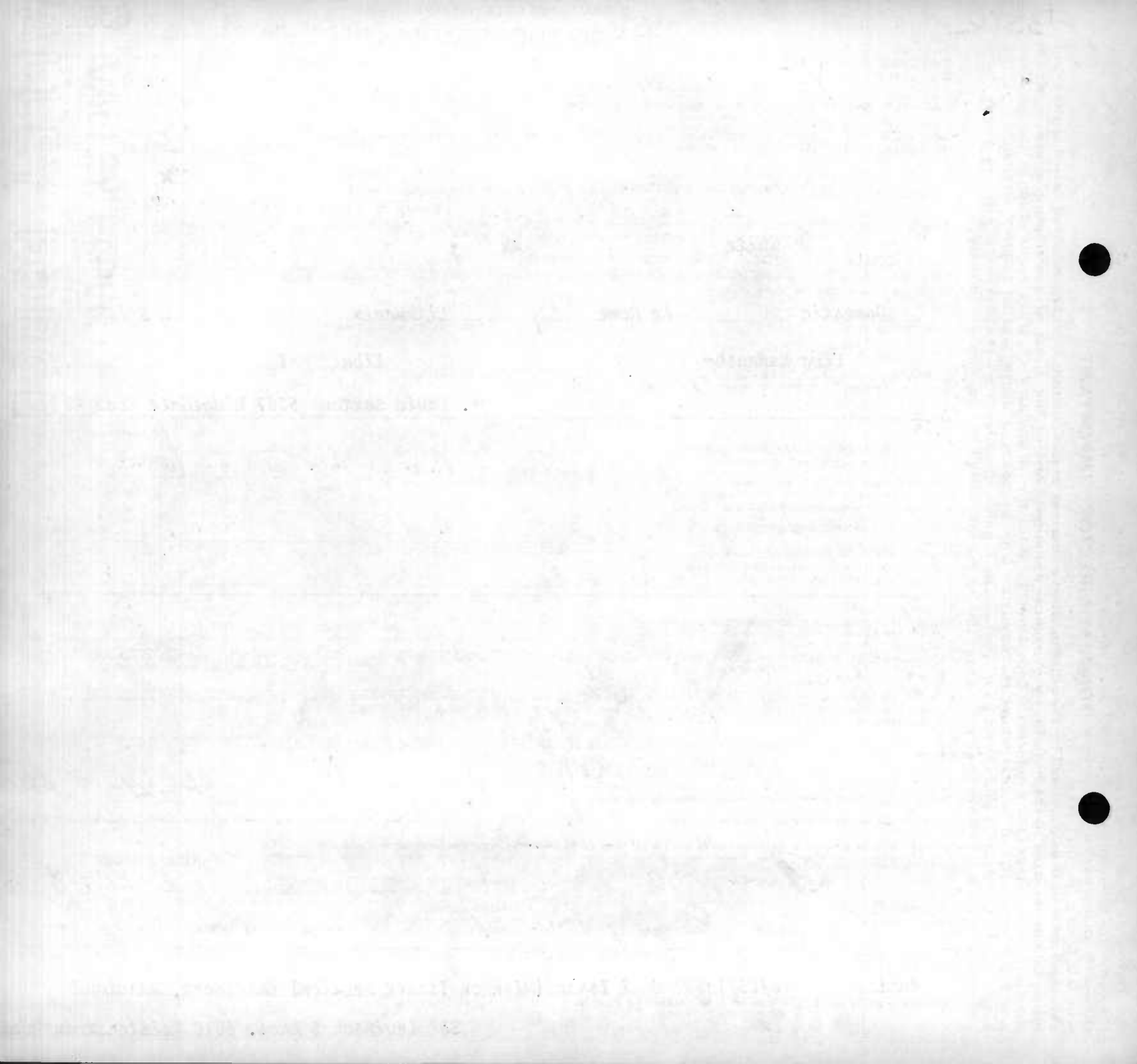
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6561

BIRTH NO.		1. NAME OF DECEASED (Type or Print) YETA KADANSKY		2. DATE AND HOUR OF DEATH 6-21-68 9 20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 13-02	
FULL NAME OF HOSPITAL OR INSTITUTION LEVINDALE HEBREW HOME AND INFIRMARY, BALT. MD.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 827 WHITELOCK STREET	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 18 73	9. AGE (In years last birthday) 95
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Lithuania	
13. FATHER'S NAME Elya Kadansky		14. MOTHER'S MAIDEN NAME Liba ?		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. David Saxton 5707 Ridgedale Road #9	
18. 4 10 9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
18. 4 20 1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> No		21F. HOW DID INJURY OCCUR? No	
22. I certify that (H) (this hospital) attended the deceased from 6-21-68 to 6-21-68 , that (U) (we) lost saw the deceased alive on 6-21-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jeff Parker, M.D.				23B. DATE SIGNED 6-21-68	
23C. PHYSICIAN'S NAME (Type) JEFF PARKER, M.D.				23D. ADDRESS LEVINDALE HEBREW HOME AND INFIRMARY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/1968		24C. NAME of CEMETERY or CREMATORY Bnai Israel (Mishkon Israel Section) Baltimore, Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6562
5-432		68- 6562		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SAMUEL SELETSKY</u>		
2. DATE AND HOUR OF DEATH <u>6-24-68</u> <u>7¹⁰</u> <u>A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7411 KALTON COURT #21208</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1903</u>	9. AGE (In years lost birthday) <u>65</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>BOSTON, MASSACHUSETTS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JACOB SELETSKY</u>		
14. MOTHER'S MAIDEN NAME <u>CECELIA SOCKOWITZ</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>216-09-1850</u>		17. INFORMANT <u>MRS. BESS SELETSKY, 7411 KALTON CT. #21208</u>		
18. I <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>acute coronary thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>coronary atherosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 yrs</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>420.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1957</u> 19 to <u>6/24/68</u> 19 that (I) (we) last saw the deceased alive on <u>6/24/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Milton B. Kirsh</u>		23B. DATE SIGNED <u>6/24/68</u>		23C. PHYSICIAN'S NAME (Type) <u>MILTON B. KIRSH</u>
23D. ADDRESS <u>4000 W. NORTHERN PARKWAY</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>6-25-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1968</u>		25B. NAME OF REGISTRAR <u>John B. Feltner</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN RD.</u>

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DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6563 CERTIFICATE OF DEATH

REG. NO. 68- 6563

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PAULINE ORENZEL		2. DATE AND HOUR OF DEATH 6-22-68 2:00 A.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-38		
FULL NAME OF HOSPITAL OR INSTITUTION LEVINSON & HARRIS Home And Infirmary 91 Balt., MD			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		8. DATE OF BIRTH July 1878	
13. FATHER'S NAME Abraham Jacob Wesler		14. MOTHER'S MAIDEN NAME Faiga Bluma ?		9. AGE (in years last birthday) 89	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. PLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA		17. INFORMANT ADDRESS Mrs. Laura Greenebaum 11 Slade Ave. Apt. 209			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 6-7 wks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) No		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? No	
22. I certify that (1) (this hospital) attended the deceased from 8-22 19 63 to 6-22 19 68 , that (I) (was) last saw the deceased alive on 6-21 19 68 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Parker				23B. DATE SIGNED 6-22-68	
23C. PHYSICIAN'S NAME (Type) J. PARKER, M.D.				23D. ADDRESS LEVINSON & HARRIS Home And Infirmary	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/23/1968		24C. NAME OF CEMETERY or CREMATORY Tzemech Zedek Shomra Adaath German Hill Rd. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6564	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARTHA WELLS		June 23 1968 9:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home 90 BALTIMORE City			A. STATE Maryland B. COUNTY 12-06 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2327 N. Charles Street		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-79	9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James H. Hensley			14. MOTHER'S MAIDEN NAME Amanda C. Qualls		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-58-8231	17. INFORMANT ADDRESS Eva Hutchinson- 2525 N. John Marshall Arlington, Virginia		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Antecedent Causes OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II Decubitus Ulcers - Urinary Infection			CAUSE OF DEATH (A) IMMEDIATE CAUSE Intractable C.H.F. 4 months DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD - Old Myocardial Infarct years (C) Generalized Arteriosclerosis 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-21-1968 to 6-23-1968, that (I) (we) last saw the deceased alive on 6-23-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cesar Valle Cauero			23B. DATE SIGNED 6-23-68		23C. PHYSICIAN'S NAME (Type) CESAR VALLE CAUERO
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/25/68		24C. NAME of CEMETERY or CREMATORY National Mem. Park
24D. LOCATION Falls Church, Virginia			24E. FUNERAL DIRECTOR 1102 W. Broad St. Falls Church F.H., Falls Church, Va.		
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			25B. NAME OF REGISTRAR R. E. Taylor		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 68- 6565 CERTIFICATE OF DEATH

REG. NO. 68- 6565

BIRTH NO.		1. NAME OF DECEASED (Type or Print) THOMAS, Aurelius NMN		2. DATE AND HOUR OF DEATH 6-17-68 10:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE District of Columbia B. COUNTY V- 48	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Washington D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1351 E Street SE					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-26	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Columbia, S. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Leander Thomas			14. MOTHER'S MAIDEN NAME Cora Gardner		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) Yes 10-19-44 to 4-19-46		16. SOCIAL SECURITY NO. 579-26-75-21		17. INFORMANT VA Hospital Records ADDRESS 3900 Loch Raven Blvd, Baltimore, Md 21218	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPLEURAL FISTULA (B) DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF ESOPHAGUS (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Month 1 Month 6 Months	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22, 19 68 to June 17, 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 17, 19 68 and that in XXX (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE Ralph H. Twining				23B. DATE SIGNED June 20, 1968	
23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING, M. D.				23D. ADDRESS Veterans Hospital 3900 Loch Raven Blvd, Baltimore, Md. 21218	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 6-22-68		24C. NAME OF CEMETERY or CREMATORY Lincoln Memorial Cemetery Suitland Maryland	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968			
25B. NAME OF REGISTRAR John & Jenkins Funeral Home		25C. FUNERAL DIRECTOR ADDRESS Washington, D. C.			

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5-352

68-6566

BALTIMORE CITY HEALTH DEPARTMENT

68-6566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) FRANK M STANSBURY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968 Hour 9:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Apt. 1201, 301 McMechen Street		3. DATE PRONOUNCED DEAD Month Day Year June 23, 1968 Hour 10:05 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-01	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/4/14		10. AGE (In years last birthday) 54	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER Memorial Apts. 301 McMechen St. - Apt. 1201
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John H.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		14B. KIND OF BUSINESS OR INDUSTRY State Tax Dept.		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. ?		18. INFORMANT ADDRESS Philander B. Briscoe Equitable Bld.	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 9778 X II					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) roof - Memorial Apts. - 301 McMechen St.	
22D. TIME OF INJURY (APPROX.) 6/23/68 9:45 A.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. jumped from 12th floor roof	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/24/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/68	24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Paul E. Chenoweth Jr.		25C. FUNERAL DIRECTOR ADDRESS 3617 Chestnut Ave.	

x

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WILLIAMSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6567

CITY HEALTH DEPARTMENT
BALTIMORE CITY
CERTIFICATE OF DEATH

REG. NO.

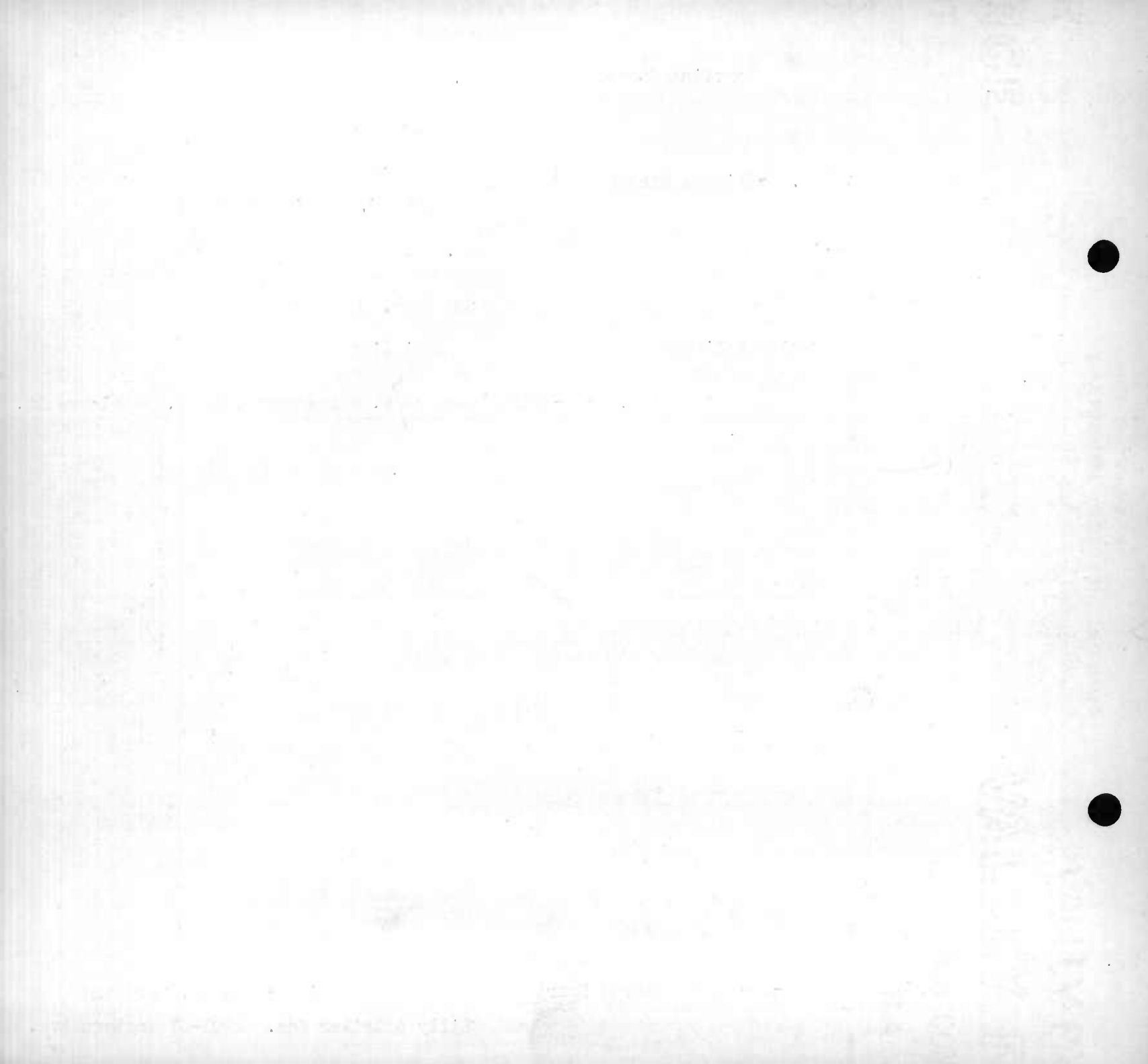
68- 6567

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>William McCoy</u>		2. DATE AND HOUR OF DEATH <u>6-21-68</u> <u>4:15</u> <u>AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>AA</u> C. CITY OR TOWN <u>Arnold</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Rt. #3 Box 5</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/10</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Inspections Labor + Industry</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>State of Md</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>David McCoy</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Ford</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u>		
16. SOCIAL SECURITY NO. <u>-</u>			17. INFORMANT <u>Mary F. McCoy</u>		
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease 8 yv.</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic cardiovascular disease 8 yv.</u> (C) <u>1 month</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>WHERE DID INJURY OCCUR?</u> (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21C. HOW DID INJURY OCCUR?	
21D. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (1) (this hospital) attended the deceased from <u>6/18/68</u> 19 to <u>6/20</u> 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>6/21/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Albert B. Einstein Jr. M.D.</u>				23B. DATE SIGNED <u>6/21/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Albert B. Einstein Jr. M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/25/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fickner</u>		25C. FUNERAL DIRECTOR <u>Albert B. Einstein Jr. M.D.</u>			
25D. ADDRESS <u>Severna Park</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6568	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p>Carolina Strassner</p> </div> <div> <p>2. DATE AND HOUR OF DEATH</p> <p>June 24 1968</p> </div> </div>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>00 2746 E. Baltimore Street</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Maryland B. COUNTY 6-02</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 2746 E. Baltimore Street</p>		
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Aug. 14, 1885</p>	<p>9. AGE (In years lost birthday) 82</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Own Home</p>		<p>11. BIRTHPLACE (State or foreign country) New York, New York</p>	
<p>13. FATHER'S NAME Louis Tagliabue</p>			<p>14. MOTHER'S MAIDEN NAME Angiolina</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 216-46-7513</p>		<p>17. INFORMANT ADDRESS Lawrence F. Strassner 2746 E. Baltimore St.</p>	
<p>18. CAUSE OF DEATH</p> <div style="display: flex;"> <div style="flex: 1;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma metastatic</p> <p>(B) Carcinoma breast</p> <p>(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 yr</p> <p>5 yr</p> </div> </div>					
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 6/24 19 68 to 6/24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Mamie Feldman</p>				<p>23B. DATE SIGNED 6/24/68</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 6-27-1968</p>	<p>24C. NAME of CEMETERY or CREMATORY Sacred Heart</p>	<p>24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968</p>		<p>25B. NAME OF REGISTRAR Robert E. Feldman</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6569	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Rose E. Findley</u>		2. DATE AND HOUR OF DEATH <u>6/21/68</u> <u>9</u> <u>A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. Hsp</u> <u>Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Prince Georges</u>		
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/10/09</u>
9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Phone Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles S. Noakes</u>				14. MOTHER'S MAIDEN NAME <u>Bertha N. [unclear]</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-1891</u>		17. INFORMANT <u>James A. Findley</u> <u>4805 52nd Ave.</u> <u>Edmonston, md</u>		
18. <u>194.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Emboli</u> (B) <u>Cancer of Adrenal Gland</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Minutes</u>
19. <u>195.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>6/5</u> <u>19 68</u> to <u>6/21</u> <u>19 68</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> <u>19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>Michael Kaliner</u>				23B. DATE SIGNED <u>6-21-68</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael Kaliner</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/25/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Ft. Lincoln</u>		24D. LOCATION (City, town, or county) (State) <u>Colmar Manor Prince George's</u> <u>Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 26 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Findley</u>		25C. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u> <u>Hyattsville, Md.</u>		

FOOTING

W/ALPH

46-27-02

CEK

F-422

68-6570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-6570

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Winnie Fowlkes

2. DATE AND HOUR OF DEATH

6/25/68

2:30 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

9-08

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2060 Kennedy Avenue #21218

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

3-25-09

9. AGE (In years last birthday)

59

If Under 1 Yr.

Months

Days

Hours

Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Fowlkes

14. MOTHER'S MAIDEN NAME

Louise Dinah Fowlkes

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS #21224

BCH Records: 4940 Eastern Ave., Balto., Md.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Hypertension, Sepsis, CVA

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 weeks

(B) DUE TO, OR AS A CONSEQUENCE OF:

UTI - chronic + acute

3 months

(C) DUE TO, OR AS A CONSEQUENCE OF:

Acute myelocytic leukemia

2 yrs.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

19C. AUTOPSY? (Yes or No)

No NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At Work ☐Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/2 19 68 to 6/25/68 19 68, that (I) (we) lost saw the deceased alive on 6/24/68 19 68 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tahamag Ismail Beigi, M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/25/68

23C. PHYSICIAN'S NAME (Type)

DR. T. ISMAIL-BEIGI, M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave., Balto., Md. #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-29-68

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 26 1968

25B. NAME OF REGISTRAR

Robert E. Fowlkes

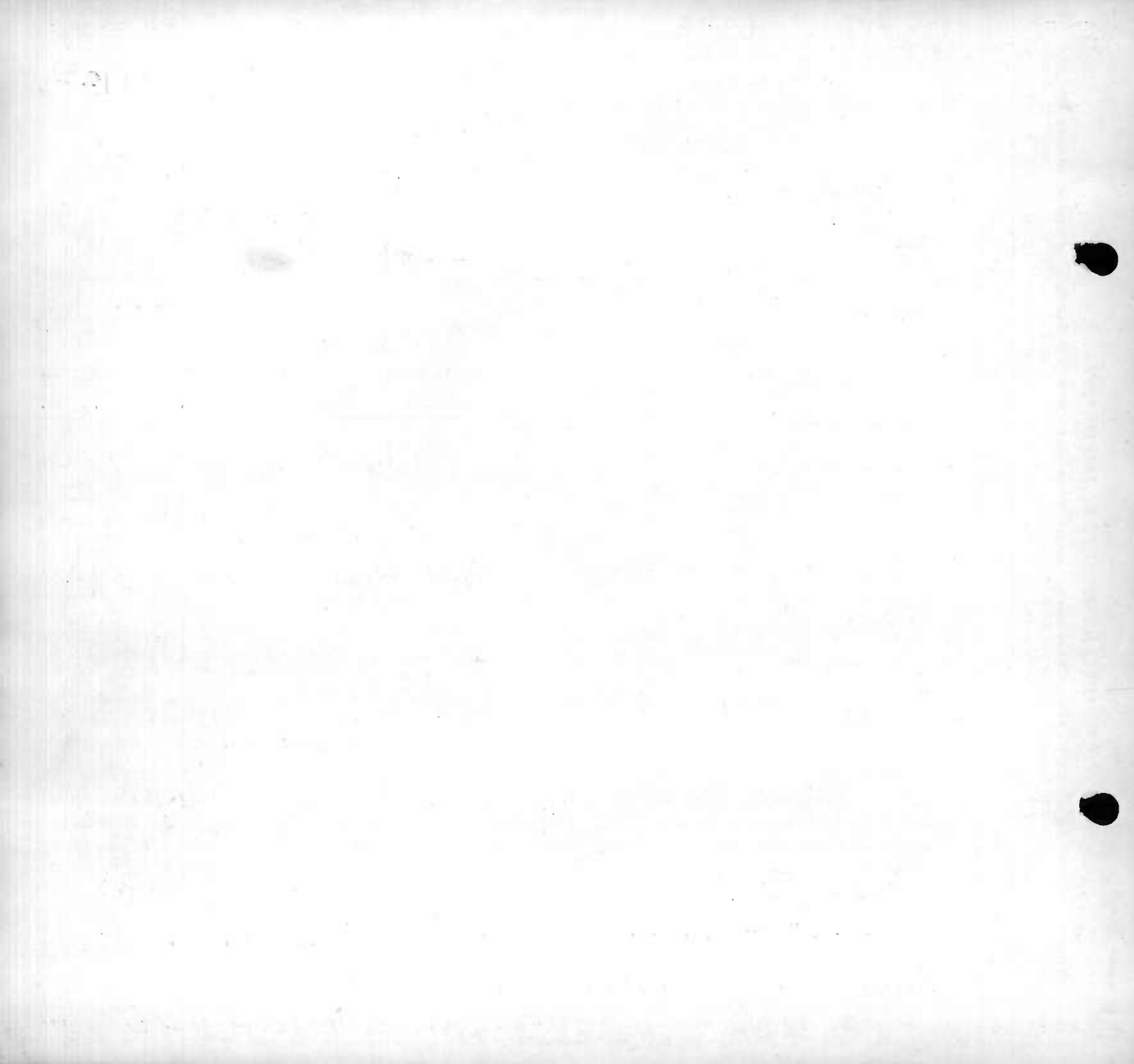
25C. FUNERAL DIRECTOR

WMB 87 MARCH 928 E. North Ave.

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6572
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT CAMPBELL JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 21, 1968 8:00 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1905 Sherwood Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 21, 1968 8:00 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 5-07	
9. DATE OF BIRTH 8/17/38		10. AGE (In years last birthday) 29 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME Robert Campbell		15. MOTHER'S MAIDEN NAME Julia Marshall	
18. INFORMANT M's Julia Campbell,		ADDRESS same	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous Narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED June 22, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68	
24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County M.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR A Halstead		ADDRESS 1206 W North Ave	

WALTER
25/11/60
P. M. K.

P-600

68-6573 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6573

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)
LAURA

PERRY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

June

23,

1968

11:45 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Hopkins Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June

23,

1968

11:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4/23/28

10. AGE (in years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1301 E. Eager St.

11. BIRTHPLACE (State or foreign country)

P.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

WILEY CORNWELL

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Delia Haynes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

Delia Cornwell 1111 N. Central Ave

ADDRESS

19.

E987X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Craneo-Cerebral Injury

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

E978X II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

O

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1301 E. Eager St.

22D. TIME (Month) (Day) (Year) (Hour)

6/23/68 11:40 P. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

subj. fell or jumped
from third floor window.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/68

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/28/68

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cem

24D. LOCATION (City, town, or county)

Q. & Q. County, Md

25A. DATE REC'D BY HEALTH DEPT.

JUN 26 1968

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Joseph B. Locks 1304 N. Central Ave

ADDRESS

14 23/4

14 23/4

14 23/4

14 23/4

14 23/4

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14 23/4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6574

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN A. GREEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 25 68 3:10 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1043 Harlem Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 25, 1968 3:10 p M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-01			
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.
9. DATE OF BIRTH 9-15-1888	10. AGE (In years last birthday) 79	11. BIRTHPLACE (State or foreign country) Hampton, S. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		14B. KIND OF BUSINESS OR INDUSTRY 1043 Harlem Ave.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-22-6745	
18. INFORMANT Marie Green - 1043 Harlem Ave.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 163X		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 26, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-29-68	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968	25B. NAME OF REGISTRAR Robert E. Fairbanks	25C. FUNERAL DIRECTOR Charles R. Law	ADDRESS 802 Madison Ave.

VALLEY OF DEATH

2006-01-11

1000 ft

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 6575 CERTIFICATE OF DEATH

REG. NO. 68- 6575

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		JAY. N. HORTON		6/24/68 8:00a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
38 UNIVERSITY HOSPITAL BALTIMORE				MARYLAND 11-01	
5. SEX		6. RACE		C. CITY OR TOWN	
M.		C		BALTIMORE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/5/17		50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LABOURER.		CONSTRUCTION		S. CAROLINA.	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?	
ED. HORTON.				U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				CARRIE HORTON, 425 WATTY COURT.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTecedent CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL HEMORRHAGE. 2 MONTHS.					
(B) ATHEROSCLEROSIS					
(C)					
331X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2.				YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/1/1968 to 6/24/1968 that (I) (we) last saw the deceased alive on 6/23/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
F. KEMBLE MD.				6/24/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
F. KEMBLE MD.				UNIVERSITY OF MD. HOSP. BALT. MD. 21201.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-27-68		Mt. Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 26 1968		Robert E. Fairburne		Charles R. Law 802 Madison Ave.	

UNIVERSITY WORK

2/2/12

CONSTRUCTION - 2 CARPENTERS

BRICKS

CRACKS

CRACKS

INTERIOR

NO

2/1/12

REMARKS

UNIVERSITY

Robert ...

PUEBLO
CVA

Board of ...

James ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6577 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6577

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LONNIE A. GARBER		2. DATE AND HOUR OF DEATH 6/26/68 4 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-48		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/9/84		9. AGE (In years last birthday) 84		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN Eli Stame		14. MOTHER'S MAIDEN NAME UNKNOWN Mary Muel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Matt Gates ADDRESS 7194 Channing St.	
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Brauclo pneumonia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 491X II				Y.S.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 68 to 6/26 19 68 , that (I) (we) last saw the deceased alive on 6/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE W. H. Rehlert Jr. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/26/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY Egan Valley	
24D. LOCATION Baltimore		(City, town, or county)		(State) Po.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR J. H. Rehlert ADDRESS Channing St.	

Handwritten signature

2. Y

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
68- 6578 CERTIFICATE OF DEATH

REG. NO. 68- 6578

BIRTH NO.		1. NAME OF DECEASED (Type or Print) STUMPF, JOSEPH CHARLES JOHN		2. DATE AND HOUR OF DEATH JUNE 22, 1968 8:03A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 20-08		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MD. 21229			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 10 SOUTH AGUSTA AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 30 1909	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY BALTO. GAS. ELEC.		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME CHARLES STUMPF			14. MOTHER'S MAIDEN NAME ELEANOR FISHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. #2		16. SOCIAL SECURITY NO. 212 03 5722		17. INFORMANT BALTO., MD. 21229 ST. AGNES RECORDS-CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 190.9 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 190.9 II			CAUSE OF DEATH (A) IMMEDIATELY DUE TO, OR AS A CONSEQUENCE OF: Malignant melanoma in (B) GENERALIZED METASTASES DUE TO, OR AS A CONSEQUENCE OF: Generalized metastases (C) _____		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 14 1968 to JUNE 22 1968 , that (X) (we) last saw the deceased alive on JUNE 22 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (XX) view the body after death.					
23A. SIGNATURE Charles J. Lancelotta Jr. M.D.				23B. DATE SIGNED 06-22-68	
23C. PHYSICIAN'S NAME (Type) CHARLES J. LANCELOTTA JR. MD.		23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 26, 68		24C. NAME OF CEMETERY or CREMATORY Baltimore, National Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. Truman Schwab, 3512 Frederick Ave. Baltimore, Maryland, 21229			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6579
BIRTH NO.				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
WAGNER, EDWARD CLARENCE		JUNE 22, 1968 4:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND		
40		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
		143 PALORMO AVENUE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	05/30/93	
9. AGE (In years lost birthday)		75		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		
Electrician		Kopper Co.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
JOHN WAGNER		MARY JANE KANE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		
YES		217-01-7363		
WORLD WAR 1		ST AGNES HOSPITAL'S RECORDS		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		RUPTURED ABDOMINAL ANEURYSM		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) ATHEROSCLEROSIS AORTA		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
43-IX II		PULMONARY EMPHYSEMA		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
6/21/68		RUPTURED ABD ANEURYSM		
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
NO		NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
21D. TIME OF INJURY (APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from JUNE 20 19 68 to JUNE 22 19 68, that (X) (we) last saw the deceased alive on JUNE 22 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Jane V. del Pilar				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
J. DEL PILAR, M.D.		ST AGNES HOSPITAL CATON & WILKENS AVES		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		
Burial		June 25, 68		
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Meadowridge Cemetery		Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		
JUN 26 1968		G. Truman Schwab, 3512 Frederick Ave. Baltimore, Maryland, 21229		
25C. FUNERAL DIRECTOR		ADDRESS		
G. Truman Schwab, 3512 Frederick Ave. Baltimore, Maryland, 21229				

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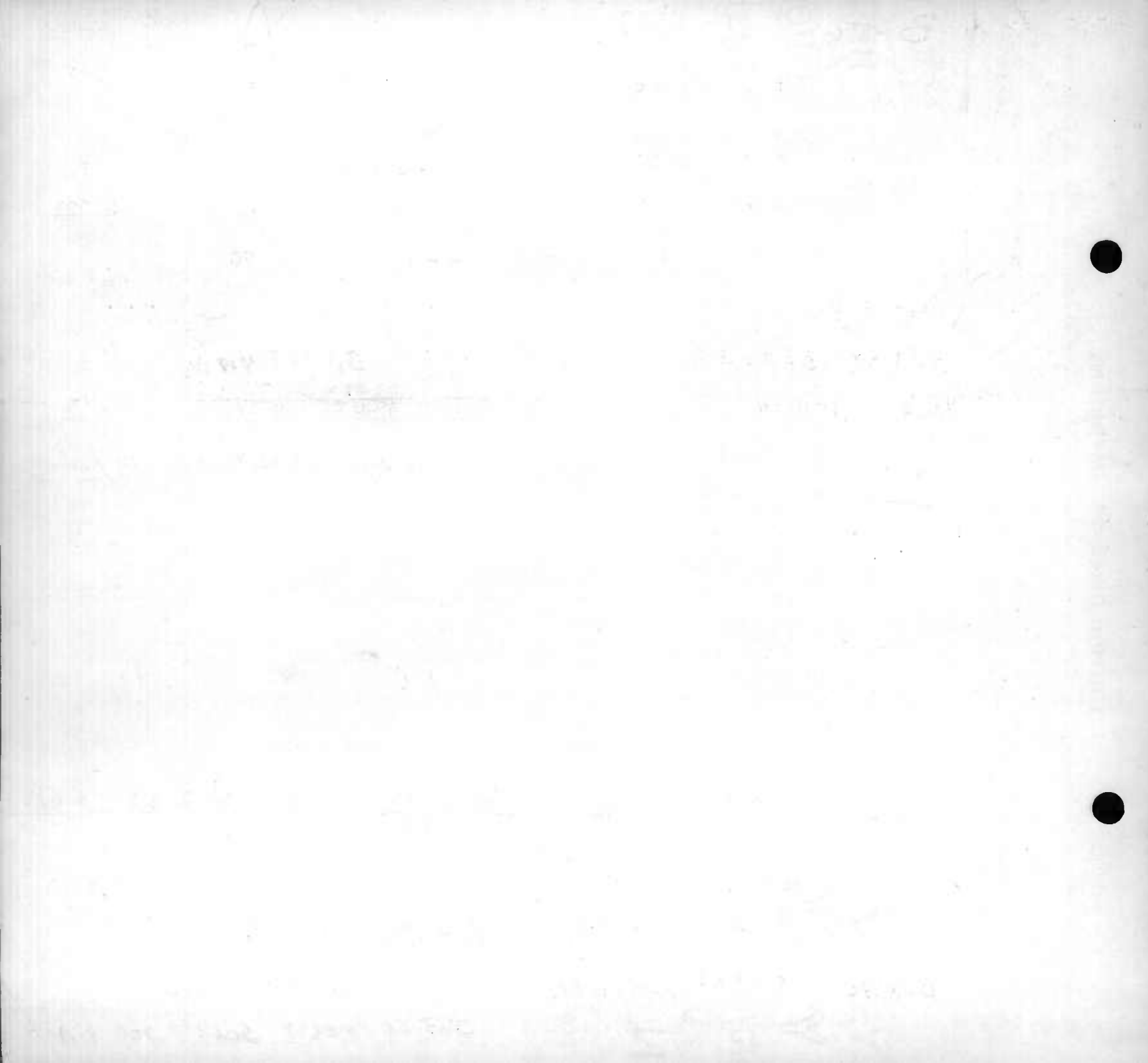
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

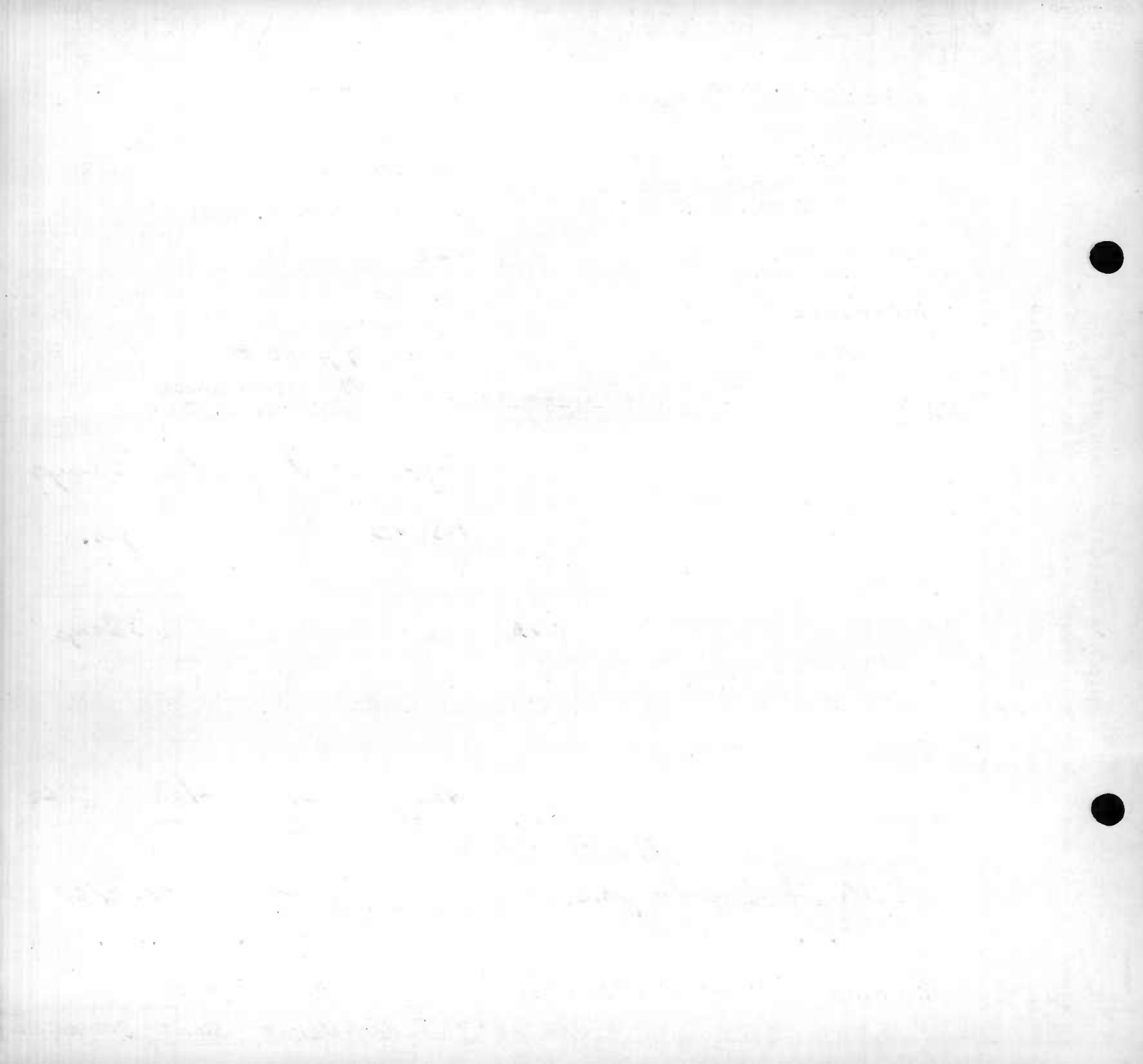
BIRTH NO. B-560		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6580	
1. NAME OF DECEASED (Type or Print) HUNTER J. BENNER			2. DATE AND HOUR OF DEATH JUNE 23, 1968 945 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE 31 BALTIMORE MARYLAND #21224			C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE			6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rest & Bar		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY BENNER			14. MOTHER'S MAIDEN NAME LUCY GRANTHAM		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS 4940 EASTERN AVENUE 21224	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hours.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 23 1968 to June 23 1968 , that (I) (we) lost saw the deceased alive on June 23 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joel Thurm M.D.			23B. DATE SIGNED June 23, 1968		
23C. PHYSICIAN'S NAME (Type) JOEL THURM M.D.			23D. ADDRESS Balt. City Hosp Balt Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY PARKWOOD	
24D. LOCATION BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968			
25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS J.G. CONNELLY SONS 300 MACE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. E-152		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6581	
1. NAME OF DECEASED (Type or Print) Frank W. Evans			2. DATE AND HOUR OF DEATH 6-23-68 5:45 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Ervin			14. MOTHER'S MAIDEN NAME Ellen J APHET		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 155-10-7206-1		17. INFORMANT Records: BCH
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD			(B) DUE TO, OR AS A CONSEQUENCE OF: ms.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II			CVA		3 days
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 6/20 19 68 to 6/23 19 68 , that (H) (we) lost saw the deceased alive on 6/23 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. M. Levinsohn, M.D.				23B. DATE SIGNED 6/23/68	
23C. PHYSICIAN'S NAME (Type) E. M. Levinsohn MD				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Balto., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/23/68		24C. NAME OF CEMETERY or CREMATORY MORELAND	
24D. LOCATION BALTO. MD.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR R. B. E. Johnson		25C. FUNERAL DIRECTOR J. G. CORNELLY SONS	
ADDRESS 300 MACE					



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)SMITH, HARRY EIMER
SMITH, HARRY EIMER

2. DATE AND HOUR OF DEATH

6/23/68 6-23-68 12 32:30PM P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31 Balto City Hospitals
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MD - BALTIMORE

C. CITY OR TOWN

ESSEX

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

129 Edgewater Apts - 21221 005

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-15-13

9. AGE (In years
lost birthday)

55 yrs

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BUTCHER

10B. KIND OF BUSINESS OR INDUSTRY

FOOD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WM. SMITH

14. MOTHER'S MAIDEN NAME

BESSIE MOORE

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL
SECURITY NO.

218-09-1130

17. INFORMANT

RECORDS: BALTIMORE CITY HOSPITALS

ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Renal failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) Liver cirrhosis - bleeding

(C) esophageal varices

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

5/18/68

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Bleeding esophageal varices

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

6/1

19 68 to

6/23

19 68.

that (I) (we) last saw the deceased alive on

6/23

19 68

and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Kokshanian M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/23/68

23C. PHYSICIAN'S
NAME (Type)

A. KOKSHANIAN, M.D.

23D. ADDRESS

31 Balto City Hospitals -
4940 EASTERN AVE., BALTO., MD. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

6/26/68

24C. NAME OF CEMETERY or CREMATORY

BALTO. CEM.

24D. LOCATION

BALTO. MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 28 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

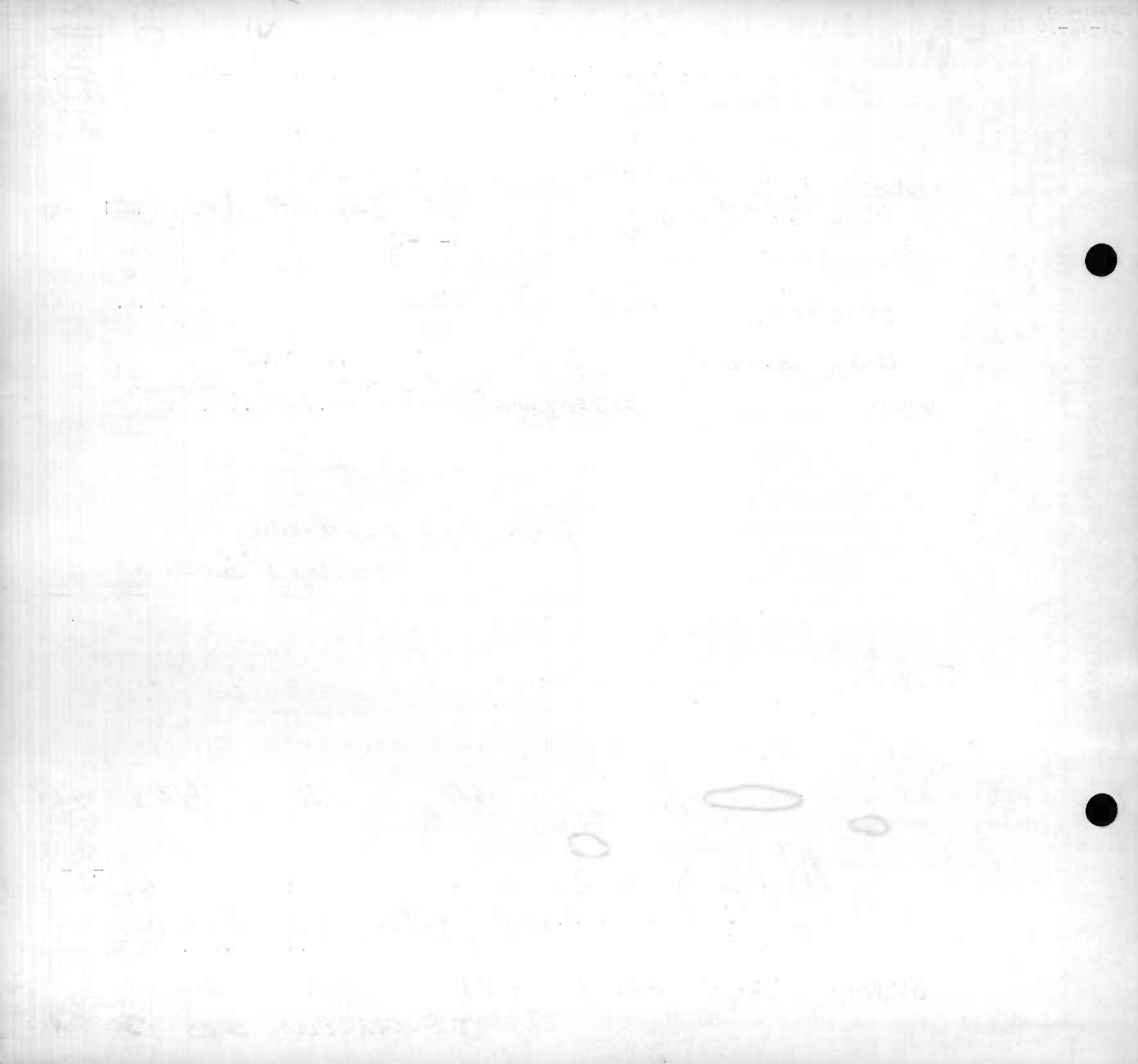
J. G. CONNELLY SONS

ADDRESS

300 MACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68- 6583

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SCHNEIDER, George McCauley, Sr.

2. DATE AND HOUR OF DEATH

June 21, 1968

10:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore Co

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1312 Sudvale Rd.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

10-24-94

9. AGE (In years lost birthday)

73

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shoe Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Matthew Schneider

14. MOTHER'S MAIDEN NAME

Isabelle McCauley

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

4-29-18 to 4-15-19

16. SOCIAL SECURITY NO.

212-07-0997

17. INFORMANT

Records

ADDRESS

V. A. Hospital, Baltimore, Md. 21218

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Pericardial and pleural

effusion

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung,

R, poorly differentiated, probably

adenocarcinoma

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C).....

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Unknown

Months

MEDICAL CERTIFICATION

163X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

6-21-68

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Thoracentesis

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 18, 1968 to June 21, 1968, that (X) (we) last saw the deceased alive on June 21, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.

23A. SIGNATURE

G. W. Gaffney, M. D.

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6-21-68

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

V. A. H. Baltimore, 3900 Loch Raven Blvd., Baltimore, Md. 21218

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

June 24/68

24C. NAME OF CEMETERY or CREMATORY

Balto. Nat. Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUN 26 1968

25B. NAME OF REGISTRAR

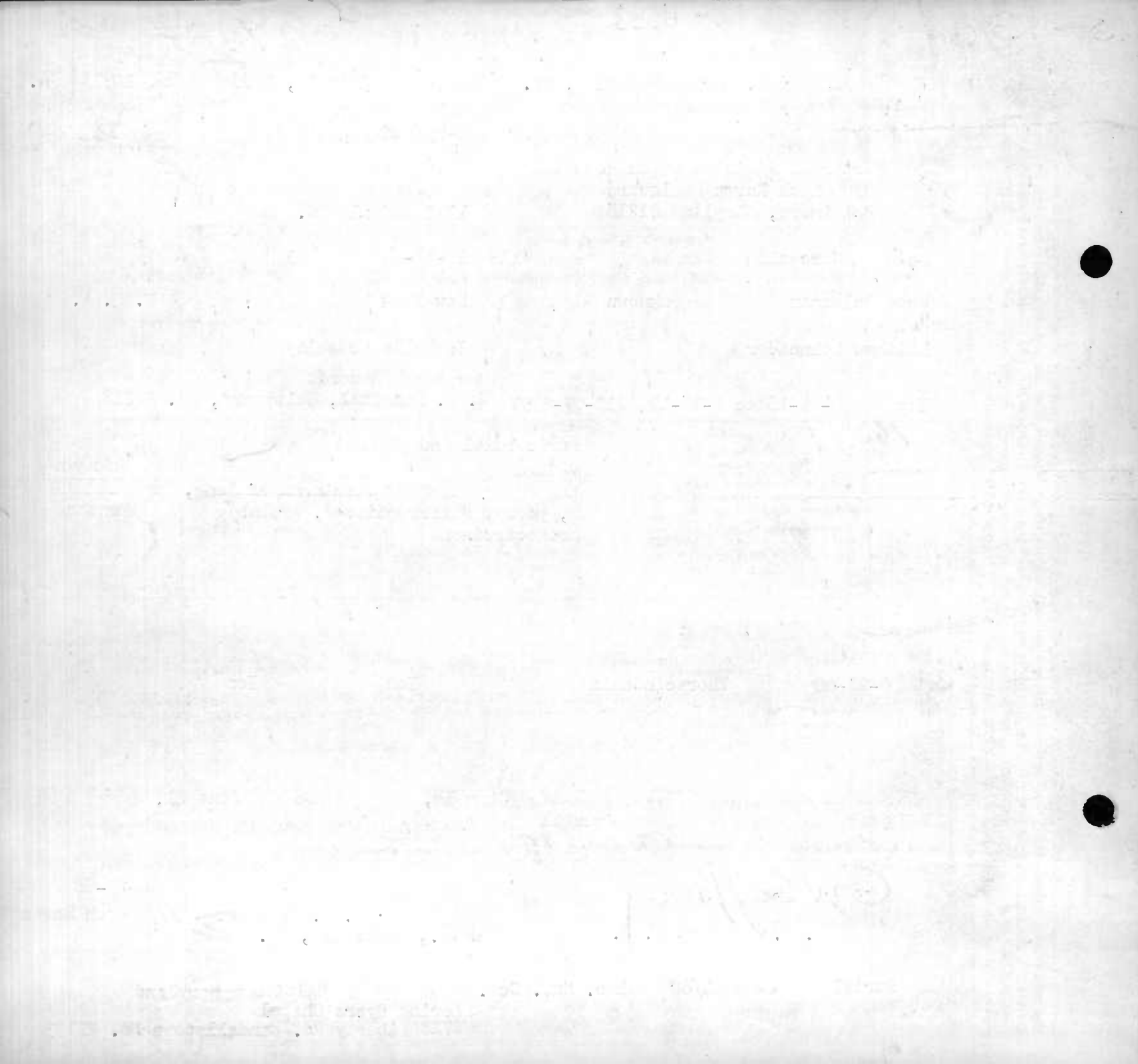
Robert E. Taylor

25C. FUNERAL DIRECTOR

Loring Byers Chapel

ADDRESS

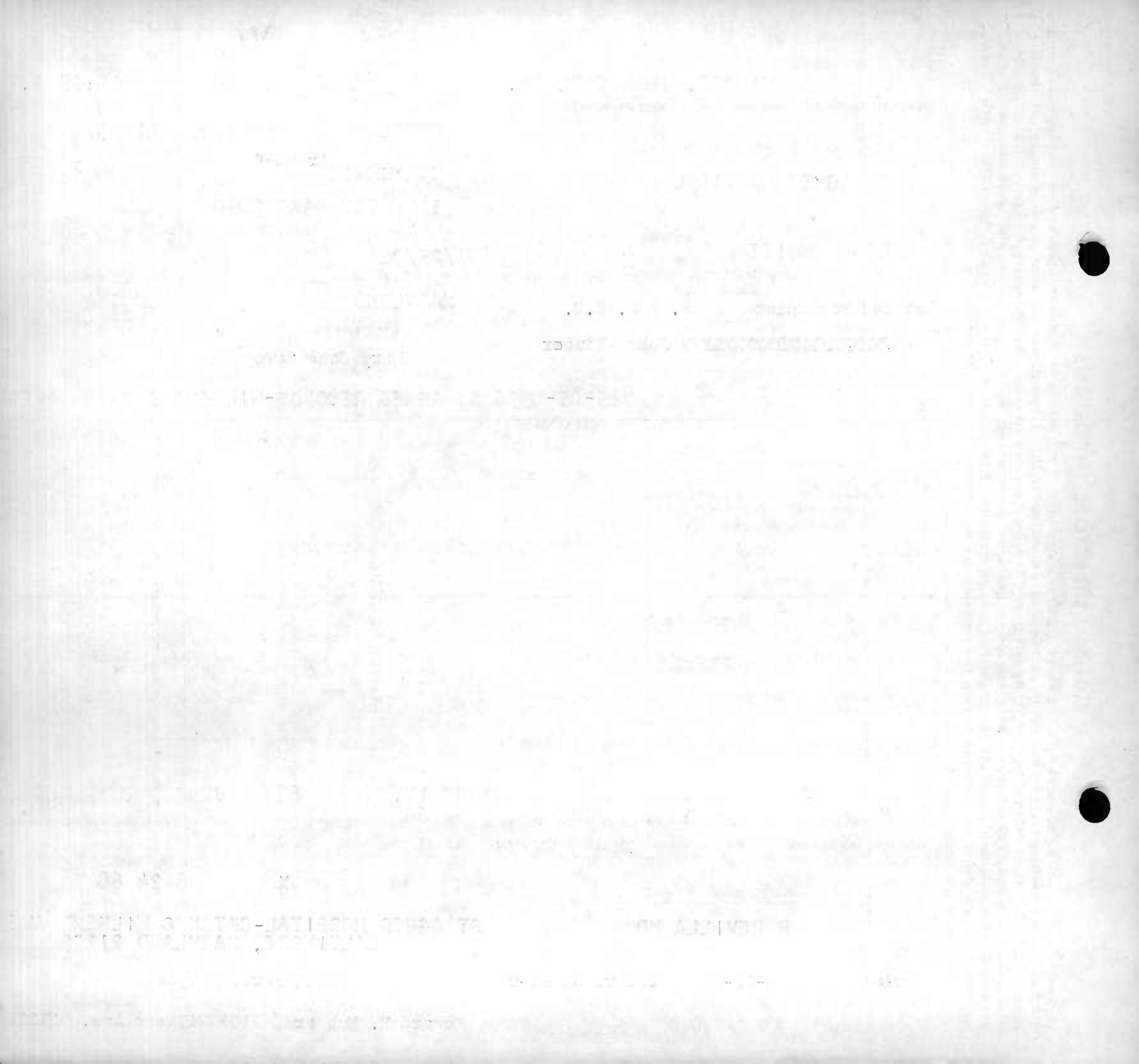
8728 Liberty Rd. Randallstown Md. 21133



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
KIMBER, JOHN CARL SR.		JUNE 24, 1968		10:35 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
ST AGNES HOSPITAL		MARYLAND Baltimore 21227		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Retired Machinist		B. & O. R.R.		02/25/94
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years lost birthday)
MARYLAND		U S A		74
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
REMIRO GONZALEZ John Kimber		Mary Jane Cavey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No		705-05-0936		ST AGNES RECORDS-WILKENS & CATON AVES
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		MYOCARDIAL INFARCTION		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
R				YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JUNE 17, 19 68 to JUNE 24, 19 68, that (X) (we) last saw the deceased alive on JUNE 24, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (IX) (We) (did) (not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
R Revilla MD		6 24 68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
R REVILLA MD		ST AGNES HOSPITAL-CATON & WILKENS AVE BALTIMORE, MARYLAND 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		6-27-68		Western Cemetery
24D. LOCATION (City, town, or county)		24E. ADDRESS		
Baltimore, Maryland		Howard H. Hubbard, 4107 Wilkens Ave. 21229		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
JUN 26 1968		R. E. Taylor		Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6585
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		CERTIFICATE OF DEATH MC CULLOUGH, GEORGE WILLIAM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		2. DATE AND HOUR OF DEATH JUNE 24 1968 5:05 P.M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 615 WASHINGTON AVENUE		
ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 13 99	9. AGE (In years lost birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY B & O RAIL ROAD		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME THOMAS J. McCullough		14. MOTHER'S MAIDEN NAME Catherine KATHERINE (BLATCHLEY)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 705053047		17. INFORMANT ST AGNES RECORDS-CATON & WILKENS AVE
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH antrolateral myocardial infarction, diffuse (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) pulmonary emboli		
19A. DATE OF OPERATION 6/20/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED cholelithiasis		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 17 1968 to JUNE 24 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 24 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Jaime V. del Pilar		23B. DATE SIGNED 6/24/68		23C. PHYSICIAN'S NAME (Type) JAIME V. DEL PILAR M.D.
23D. ADDRESS St. Agnes Hospital		23E. ADDRESS CATON & WILKENS AVES. BALTO., MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-1968		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State) Howard County, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229

RECEIVED, DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

WASHINGTON, D.C.

JUNE 15, 1964

MEMO

(MEMORANDUM FOR THE RECORD)

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JUNE 15, 1964

JUNE 15, 1964

JUNE 15, 1964

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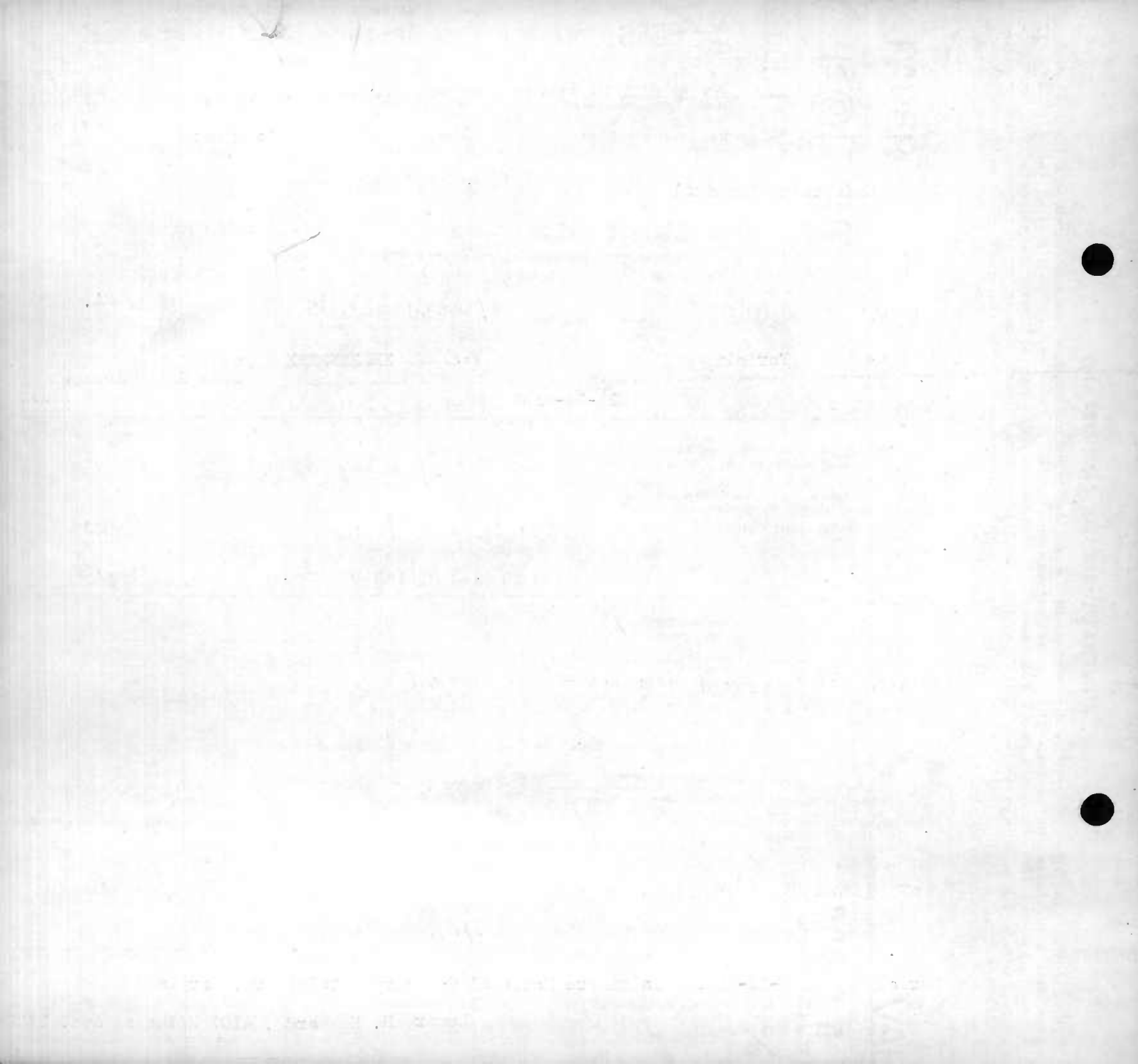
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6586 CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 68- 6586

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William Anthony Ferioli</i>		2. DATE AND HOUR OF DEATH <i>June 24, 1968</i> <i>1145 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>21227</i> <i>Baltimore</i>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) C. CITY OR TOWN <i>Lansdowne</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>		E. STREET AND NUMBER <i>2404 Smith Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>M</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/10/32</i>	9. AGE (In years last birthday) <i>35</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contract Administrator</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Massachusetts</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		13. FATHER'S NAME <i>William Ferioli</i>		14. MOTHER'S MAIDEN NAME <i>Rose Ferioli Fachini</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes Army 1953-5</i>		16. SOCIAL SECURITY NO. <i>021-24-8383</i>		17. INFORMANT <i>Regina C. Ferioli - Same</i> ADDRESS <i>2404 Smith Avenue</i> <i>21227</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>172.9</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Metastases to Brain</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Malignant Melanoma Skin</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> <i>4 mos</i> <i>4 yrs</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>190.5 - II</i>					
19A. DATE OF OPERATION <i>March 1968</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Brain Metastases</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/9/68</i> 19 to <i>6/24/68</i> 19, that (I) (we) lost saw the deceased alive on <i>6/24/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frederick K. Cressman Jr. MD</i> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/24/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>University Hospital</i> DEGREE		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-28-1968</i>		24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i> ADDRESS <i>4107 Wilkens Ave. 21229</i>	



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M-100

68- 6587 BALTIMORE CITY HEALTH DEPARTMENT

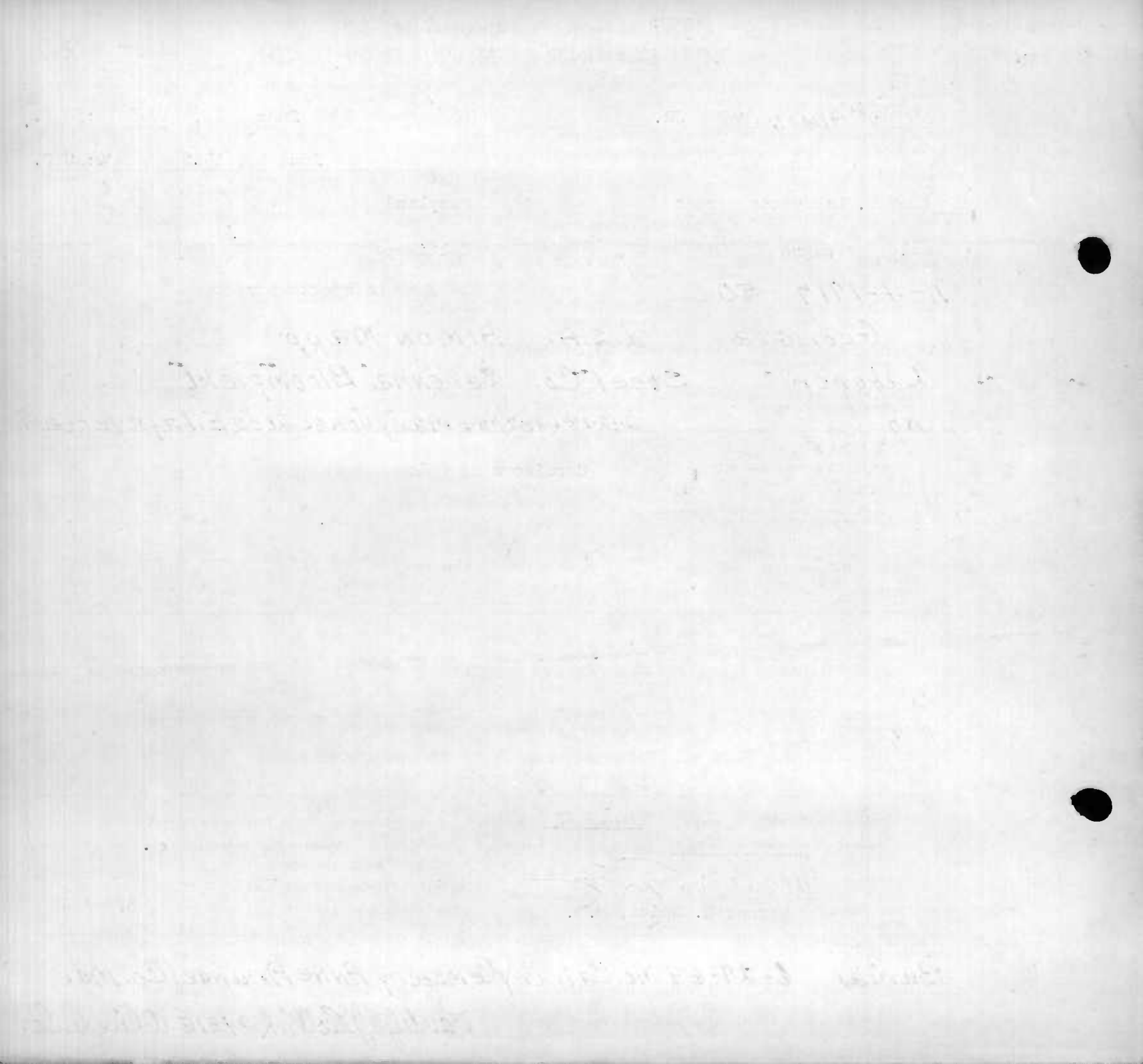
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6587

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALMOND or ALMON MAPP, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968 Hour 3:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2032 E. Lafayette Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1968 4:30 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-4-1917		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Steel Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 242-18-6282	
13. FATHER'S NAME Almon Mapp		15. MOTHER'S MAIDEN NAME Savanna Bloomfield	
18. INFORMANT Mrs Mary Jones		ADDRESS 2032 E. Lafayette Ave	
19. 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Colon		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 15-3-8 II		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 6/24/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-68	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR Randolph Collick		ADDRESS 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6588	
<div style="display: flex; justify-content: space-between;"> W-325 68- 6588 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Meredith Watkins		2. DATE AND HOUR OF DEATH 6/26/68 11:30 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland Gen. Hosp.			A. STATE Md. B. COUNTY Balto		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 920 Druid Hill Ave		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/30		9. AGE (In years lost birthday) 37
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Va	
13. FATHER'S NAME John Beverly			12. CITIZEN OF WHAT COUNTRY? U S A		
14. MOTHER'S MAIDEN NAME Blanche ? Winston					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ??		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 180X I Subhepatic abscess intestinal obstruction and gangrene passive brain abscess			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Ca of cervix, & radiation therapy (C) INTESTINAL OBSTRUCTION & PERFORATION		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1/7/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED intestinal obstruction		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 78	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cyrus Makoui				23B. DATE SIGNED 6/26/68	
23C. PHYSICIAN'S NAME (Type) CYRUS MAKOU				23D. ADDRESS 78. Gen. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/68		24C. NAME OF CEMETERY or CREMATORY Richmond	
24D. LOCATION (City, town, or county) (State) Virginia					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Adolphus Halstead	
				ADDRESS 1206 W North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6589	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) KELLNER, ELIZABETH		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> JUNE 24, 1968 6:30 P.M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location) ST AGNES HOSP. CATON & WILKENS AVE 40 BALTO MD 21229		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 22 S ATHOL AVE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 11 74	9. AGE (In years last birthday) 93	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME CHARLES			14. MOTHER'S MAIDEN NAME EMILY (KILLMAN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216546624		17. INFORMANT ADDRESS ST AGNES RECORDS-CATON & WILKENS AVE	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE <i>Intestinal obstruction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____ </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X II					
19A. DATE OF OPERATION 6-22-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Obstetrics</i>		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 21 19 68 to JUNE 24 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 24 19 68 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXXX) view the body after death.					
23A. SIGNATURE HAMID MEHDIZADEH, M D				23B. DATE SIGNED 06 24 68	
23C. PHYSICIAN'S NAME (Type) HAMID MEHDIZADEH, M D				23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968			
25B. NAME OF REGISTRAR <i>R. E. & J. F. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave. Balto, Md. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6590
BIRTH NO. R-240		68-6590 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) RUSSELL EDWARD W.		2. DATE AND HOUR OF DEATH 06-26-68 2 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hosp		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 211 N. BEECHWOOD AVE		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-14-07	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME S FRANK RUSSELL		
14. MOTHER'S MAIDEN NAME EVA SHEFFLER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 217-18-6144		17. INFORMANT SISTER MRS. EUGENE HIGDON		
18. 15779 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of pancreas		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) multiple metastasis to liver, peripancreatic area		
ANTECEDENT CAUSES		(C) to urea area		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
1577X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 05-09-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory lap. Biopsy		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 21 1968 to June 26 1968 that (I) (we) last saw the deceased alive on June 26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Pius Y Cho M.D.		23B. DATE SIGNED 06-26-68		23C. PHYSICIAN'S NAME (Type) Pius Y Cho M.D.
23D. ADDRESS Union Memorial Hospital, Balto., Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6/28/68		24C. NAME OF CEMETERY OR CREMATORY Morning Star		24D. LOCATION (City, town, or county) (State) DuBois, Pennsylvania
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke 4101 Edmondson Ave. 21229

10-25-11

The following is a list of the names of the persons who have been

admitted to the hospital since the 1st of January, 1911.

Admitted to the hospital since the 1st of January, 1911.

Admitted to the hospital since the 1st of January, 1911.

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Admitted to the hospital since the 1st of January, 1911.

Admitted to the hospital since the 1st of January, 1911.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6591	
N-550 68-6591		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) NEWMANN, SARAH B.		2. DATE AND HOUR OF DEATH JUNE 25, 1968 6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO State Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 605 ALLENDALE ST.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife	9. AGE (In years last birthday) 91 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Cavey		14. MOTHER'S MAIDEN NAME Josephine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT 5216 Cromarty Rd. Mrs. Margaret Heales, Balto., Md. 21229
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-8-1965 to June 25, 1968 , that (I) (we) last saw the deceased alive on June 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Albert Folgueras DEGREE		23B. DATE SIGNED June 25 68	
23C. PHYSICIAN'S NAME (Type) ALBERT FOLGUERAS MD DEGREE		23D. ADDRESS Montebello State Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/29/68	24C. NAME OF CEMETERY or CREMATORY St. John's	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR R. A. 2. 3. 4. 5. 6. 7. 8. 9. 0	25C. FUNERAL DIRECTOR Witzke	ADDRESS 4101 Edmondson Ave. 21229

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		BALTIMORE CITY HEALTH DEPARTMENT		68- 6592	
68- 6592		CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CARRIE I. HALL		JUNE 24, 1968 9:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Harford Gardens Convalescent Home		Maryland			
90		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2911 Markley Ave.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 23, 1882	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Pennsylvania	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Albert Bortner		Lillie Goodling			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-03-1149 D		Mrs. Doris N. Nasteff 8210 Harris Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Pulmonary edema (hypostatic) 4 hrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
422.1 II		Cerebrothrombosis 3 months			
		Arteriosclerotic C-V disease			
		and Chronic myocarditis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from Feb 7 to June 24, 1968, that (I) (we) last saw the deceased alive on June 24, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
22A. SIGNATURE		23B. DATE SIGNED			
Dr. Harold V. Harbold		June 26, 1968			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Harold V. Harbold		4706 Harford Road Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-27-68		Druid Ridge	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1968		Robert E. Fairbanks		Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212	

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Polyspermy (hypertonic)

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June 24 1907

X Dr. V. G. ...

1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH				3. DATE PRONOUNCED DEAD				4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
RUSSELL C. HATFIELD				Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 24, 1968 7:10 A.M.				Month Day Year Hour June 24, 1968 7:10 A.M.				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				A. STATE B. COUNTY Maryland			
6. SEX male				7. RACE white				B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 6/20/14				10. AGE (In years last birthday) 54				If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.				E. STREET AND NUMBER 4920 Crenshaw Ave. - Apt. D							
11. BIRTHPLACE (State or foreign country) North Dakota				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Alve Earl Hatfield											
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Officer				14B. KIND OF BUSINESS OR INDUSTRY U.S. Vet. Adm.				15. MOTHER'S MAIDEN NAME Nanie V. Holmstrom											
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II				17. SOCIAL SECURITY NO. 532-03-3511				18. INFORMANT ADDRESS Gina L. Hatfield-4920 Crenshaw Ave. Apt. D											
19. 412.4 CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Arteriosclerotic Cardiovascular Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
				ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:											
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:											
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?											
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/24/68							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/28/68				24C. NAME of CEMETERY or CREMATORY Baltimore National Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc.				ADDRESS 6009 Harford Rd.-Balto., Md. 21214							

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6594
C-635 68-6594 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) COURTNEY, EVELYN LORRAIN		
2. DATE AND HOUR OF DEATH JUNE 23, 1968 7:40P M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY ANNE ARUNDEL 21122		
5. SEX FEMALE		6. DATE OF BIRTH 11-18-19		
6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. AGE (In years lost birthday) 48		9. CITY OR TOWN PASADENA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REGISTERED NURSE		10B. KIND OF BUSINESS OR INDUSTRY PA.		
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME WILLIAM LITKA		14. MOTHER'S MAIDEN NAME KATIE KULP		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 204-18-5587		
17. INFORMANT CATON & WILKENS AVES. ADDRESS ST. AGNES HOSPITAL RECORDS		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Metastatic Carcinoma of ovary (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None		
19A. DATE OF OPERATION 175.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-20 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 23 19 68 , and that injury <input checked="" type="checkbox"/> (our) apinlan death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) view the body after death.		
23A. SIGNATURE John H. Tuohy, M.D.		23B. DATE SIGNED 6/24/68		
23C. PHYSICIAN'S NAME (Type) J.H. TUOHY, M.D.		23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/1968		
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Farkas		
25C. FUNERAL DIRECTOR GEORGE J. GONCE, 4001 Ritchie Hwy., Baltimore		25D. ADDRESS		

Metastatic (breast) of ovary

Mass

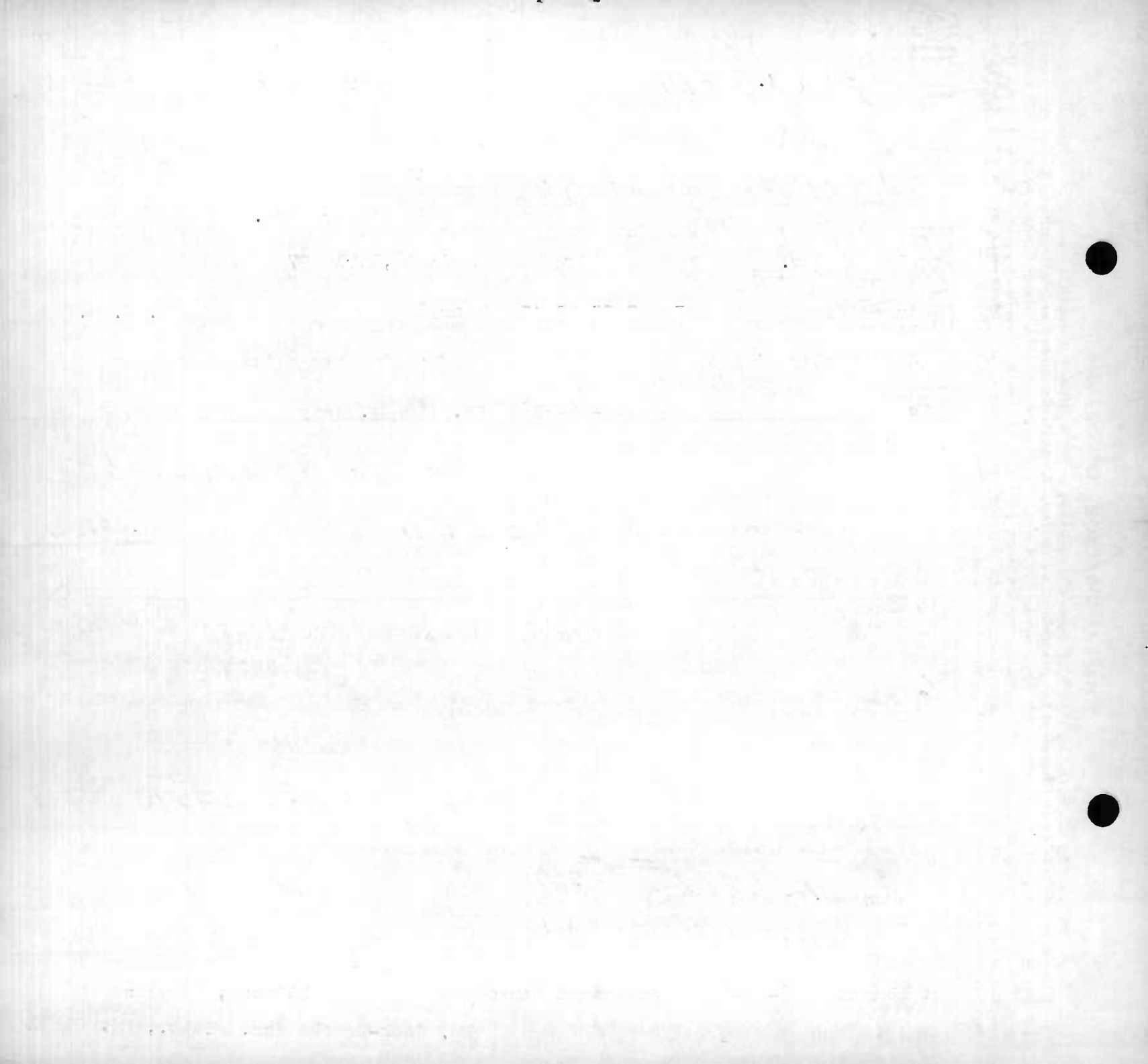
x

John W. Lusk, M.D.
L.H. Trench, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-600 68- 6595				BALTIMORE CITY HEALTH DEPARTMENT		68- 6595	
BIRTH NO.				REG. NO.		68- 6595	
1. NAME OF DECEASED (Type or Print) <u>Ella V. Gray</u>				2. DATE AND HOUR OF DEATH <u>6/24/68</u> <u>5:10 a.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital of Balto</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2900 Guilford Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>Cau.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1871</u>	9. AGE (In years last birthday) <u>97</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John Wesley Wingate</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Anna White</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-2364</u>		17. INFORMANT <u>Mr. John W. Gray</u>		ADDRESS <u>Same as #4 E</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I Myocardial Infarction 1 hr</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>AS CVD unknown</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
19. DATE OF OPERATION <u>420.1 II</u>				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> 19 <u>68</u> to <u>6/24</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Kenneth Wetcher MD</u>				23B. DATE SIGNED <u>6/24/68</u>			
23C. PHYSICIAN'S NAME (Type) <u>KENNETH WETCHER MD</u>				23D. ADDRESS <u>Sinai Hospital of Balto. Md</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u>		24B. DATE <u>6-27-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Mausoleum</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>		ADDRESS <u>Balt., Md. 21202</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6596</u>
<u>S-514</u> BIRTH NO.		68-6596 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>JOSEPH L. SCHOENFELD</u>		2. DATE AND HOUR OF DEATH <u>JUNE 25, 1968</u> <u>12:40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MT SINAI NURSING HOME</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6243 PIMLICO RD</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 2, 1902</u>	9. AGE (In years last birthday) <u>65</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUYER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>PAPER GOODS</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HERMAN</u>		
14. MOTHER'S MAIDEN NAME <u>ROSE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>075-09-8865</u>		17. INFORMANT <u>WIFE</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <u>441.21</u> <u>Ruptured abd. aneurysm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>451X II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-6-66</u> to <u>6-25-1968</u> , that (I) (we) last saw the deceased alive on <u>6-24-1968</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>K.A. Peter van Berkum, M.D.</u>
23D. ADDRESS <u>100 W. University Pkwy.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>6/26/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>
ADDRESS <u>Sylvan S. Lewis & Son, Inc 9610 Reisterstown Rd</u>				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>420-416</u>
<div style="font-size: 2em; font-weight: bold;">R-200</div> <div style="font-size: 1.5em; font-weight: bold;">68-6597</div>		<div style="font-size: 1.5em;">CERTIFICATE OF DEATH</div> <div style="font-size: 1.5em;">68-6597</div>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE E. ROSCOE</u>		2. DATE AND HOUR OF DEATH <u>6/25/68</u> <u>12-10 P. M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5028 Palmer Ave #15</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/03</u>	9. AGE (In years last birthday) <u>65</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN Roscoe</u>		
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>166-050581A</u>		17. INFORMANT <u>MARIE ADICE ROSCOE</u> <u>Dr. D.V. Harrison</u>		
18. <u>199.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hepato-Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Generalized Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. <u>199.2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>6/21/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Exploratory Laparotomy for Trauma</u>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(at)</u> this hospital attended the deceased from <u>6/14</u> 19 <u>68</u> to <u>6/25</u> 19 <u>68</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>6/25</u> 19 <u>68</u> and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.				
23A. SIGNATURE <u>Amelia M. D.</u>		23B. DATE SIGNED <u>6/25/68</u>		23C. PHYSICIAN'S NAME (Type) <u>D. J. PRADHAN, M.D.</u>
23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>6-28-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ellsworth Armacost-4600 Liberty Hghts.</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6598
1-236		68- 6598		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
EDWARD H. LEISTER, II		JUNE 24 1968 6 ¹⁰ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE Pa B. COUNTY V-35		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
USPHS Hospital			Littlestown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
2X			E. STREET AND NUMBER		
			34 W Myrtle St		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/6/43	25	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Teacher		Public School		Pa	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward H. Leister			Anna M Koontz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		199 32 1508		34 W. Myrtle St.,	
18. 202.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)			GIANT FOLLICULAR LYMPHOMA		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			PULMONARY INSUFFICIENCY		
			(B) 2° (A) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) SHOCK 2° B		
202.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			1 YEAR		
			2 MONTHS		
			3 DAYS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 19 to June 24 19 68, that (X) (we) last saw the deceased alive on June 24 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
W Leigh Thompson MD DEGREE				JUNE 24 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
W. Leigh Thompson MD DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/27/68		St. Marys Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Silver Run, Carroll Co., Md.		Richard A Little Littlestown, Pa.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1968		Robert E. Feltner		Richard A Little Littlestown, Pa.	

Richard Little

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6599	
T-610		68- 6599		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) TROUPE CLYDE WALDO		2. DATE AND HOUR OF DEATH JUNE 26, 1968 1:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21229 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 249 OAKLEE VILLAGE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 17 90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME TROUPE CALVIN F.		14. MOTHER'S MAIDEN NAME (HULL) HATTIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 1		16. SOCIAL SECURITY NO. 217328379		17. INFORMANT ADDRESS ST AGNES HSOPITAL WILKENS & CATON AVE	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3 months		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized Carcinomatosis (B) Carcinoma of colon DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
19. 153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 153.8 II					
19A. DATE OF OPERATION 4-8-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma breast		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 1, 1968 to JUNE 26, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 26, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Carl H. Matthey DEGREE				23B. DATE SIGNED 6-26-1968	
23C. PHYSICIAN'S NAME (Type) CARL H. MATTHEY, M. D. DEGREE				23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-68		24C. NAME of CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Frederick Ave. Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave.	

TO THE
HONORABLE
MEMBERS OF THE
LEGISLATIVE COUNCIL
OF THE
PROVINCE OF ONTARIO
IN PARLIAMENT ASSEMBLED
AT TORONTO
ON THE 11TH DAY OF
MAY 1907
PRESENTED BY
MR. J. H. HARRIS
OF THE
PROVINCE OF ONTARIO
IN PARLIAMENT ASSEMBLED
AT TORONTO
ON THE 11TH DAY OF
MAY 1907
BY
MR. J. H. HARRIS
OF THE
PROVINCE OF ONTARIO
IN PARLIAMENT ASSEMBLED
AT TORONTO
ON THE 11TH DAY OF
MAY 1907

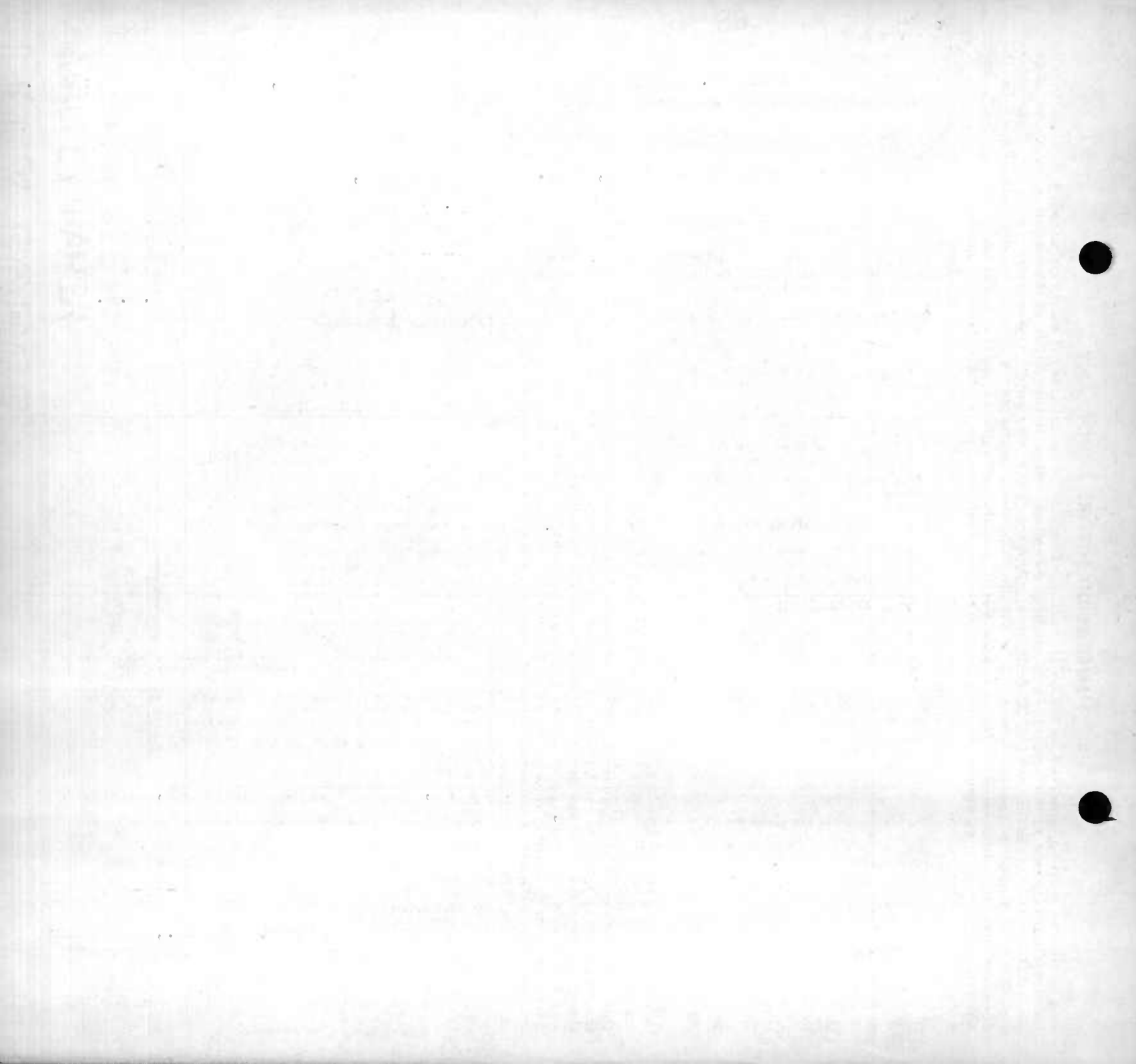
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THE
HONORABLE
MEMBERS OF THE
LEGISLATIVE COUNCIL
OF THE
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IN PARLIAMENT ASSEMBLED
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MR. J. H. HARRIS
OF THE
PROVINCE OF ONTARIO
IN PARLIAMENT ASSEMBLED
AT TORONTO
ON THE 11TH DAY OF
MAY 1907

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-651 68- 6600 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>		REG. NO. 68- 6600	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Susie E. Crump		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> June 25, 1968 6:50 A.M. </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1437 Myrtle Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1892
9. AGE (In years lost birthday) 76		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Turner		14. MOTHER'S MAIDEN NAME Susie Jenkins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Ernestine Crump-Daughter		ADDRESS SAME	
18. 440.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Embolism, massive DUE TO, OR AS A CONSEQUENCE OF: (B) Arterio & Atherosclerosis, moderate DUE TO, OR AS A CONSEQUENCE OF: (C)	
19A. DATE OF OPERATION 450.0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 18, 19 68 to June 25, 19 68 , that (I) (we) last saw the deceased alive on June 25, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Humbert Edgar		23B. DATE SIGNED 6-25-68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1514 Division Street Balto., Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-29-68	24C. NAME OF CEMETERY or CREMATORY Mt Auburn Em.	24D. LOCATION (City, town, or county) (State) Balto Md
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR Robert E. Fajardo	25C. FUNERAL DIRECTOR Francis J. Hensley	ADDRESS 578 W Biddle St



CASE DR. SPITZ.
 Not A Medical Examiner
 FUNERAL DIRECTOR: IMPORTANT
 DR. SPITZ.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-260 68-6601				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6601	
1. NAME OF DECEASED (Type or Print) MAZER BENJAMIN				2. DATE AND HOUR OF DEATH June 25-1968 9:45 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. HENRY HOME and Hosp. Fayette & Broadway #31				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO City C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 MAIN AVENUE 07			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH [REDACTED]	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE			10B. KIND OF BUSINESS OR INDUSTRY PROPRIETOR		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME [REDACTED] BENZION MAZER			14. MOTHER'S MAIDEN NAME BRINA UNKNOWN ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213 28-6390		17. INFORMANT MRS. BESSIE MAZER, ADDRESS 4000 MAINE AVENUE #21207		
18. 153.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (1) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST DURING ANESTHESIA - (2) A.S.H.D. (3) CARCINOMA OF DESC. COLON			
19. 153.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chr. Pulm. Tbc & CA-metastatic				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 16-25-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA COLON		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X		21C. WHERE DID INJURY OCCUR? X		(If In Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/10/1968 to 6/25/1968 , that (I) (we) last saw the deceased alive on 6/25/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 9:45 AM							
23A. SIGNATURE Alberto Zapata MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/25/68	
23C. PHYSICIAN'S NAME (Type) ALBERTO ZAPATA MD				23D. ADDRESS JOPPA MEDICAL CENTER JOPPA & OLD HARFORD Rd. 34			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-68		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Faltus		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6602
F 513		68-6602		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Finifter, Bessye		2. DATE AND HOUR OF DEATH 6-24-68 3:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI Hosp. of Balto		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BOLKE 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7908 DUNHILL VILLAGE CIRCLE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1911	9. AGE (In years last birthday) 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN		10B. KIND OF BUSINESS OR INDUSTRY HOCHSCHILD KOHN & CO.		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ABRAHAM H. KURLAND		
14. MOTHER'S MAIDEN NAME SARAH FANNIE ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT DR. BURTON M. FINIFTER, 3927 ALGIERS ROAD RANDALLSTOWN, MARYLAND 21133		
18. 1531 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CARCINOMATOSIS & LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Adeno CA. to LIVER (B) @ Lung @ Clavicle @ Axilla 5-6 MONTHS DUE TO, OR AS A CONSEQUENCE OF: (C) Papillary Adeno CA Hepatic Flexure 1-2 yrs.		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-10 days.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1531 II				
19A. DATE OF OPERATION 07-28-68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Papillary Adenoma of hepatic flexure.	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5-11-1968 to 6-24-1968 , that (I) (we) last saw the deceased alive on 6-24-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Galvez		23B. DATE SIGNED 6-24-68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) EDITO C. GALVEZ MD		23D. ADDRESS SINAI Hosp. of Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-25-68	24C. NAME OF CEMETERY or CREMATORY (TZEMECH ZEDEK) SHOMRA ADATH	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR Ed. C. Galvez	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		

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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. L-150		68- 6603 CERTIFICATE OF DEATH				Registered No. 4100 65 68- 6603				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) SAMUEL LEVIN					6/25/68 5:25P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(If not in hospital or institution, give street address or location)			A. STATE MD.		B. COUNTY 27-20			
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.					
					D. STREET ADDRESS (If rural, give location) 3020 Fallstaff Manor Apt. # 9.					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday) 63		
				MARRIED				If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY CLOTHING			11. BIRTHPLACE (State or foreign country) Balto, MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL LEVIN					14. MOTHER'S MAIDEN NAME LENA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MRS. SARAH LEVIN			ADDRESS 3000 F FALLSTAFF MANOR COURT #21209		
18. 170.2/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis.					(A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					
					(C) DUE TO					
19. 196.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 05/17/68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Metastatic			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (if this hospital) attended the deceased from 5/14 19 68 to 6/25 19 68 , that (I) was last saw the deceased alive on 6/25 19 68 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.										
23A. SIGNATURE [Signature]								23B. DATE SIGNED 6/25/68		
23C. PHYSICIAN'S NAME (Type) D. V. PRADHAN					23D. ADDRESS SINAI HOSPITAL OF BALTO.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-68		24C. NAME OF CEMETERY or CREMATORY SHAAREI TFILOH			24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968			25B. NAME OF REGISTRAR [Signature]			25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				

NAME WHITE MYSTIFIED

SATISFACTION

EXAMINATION

MARKS

1.2.4

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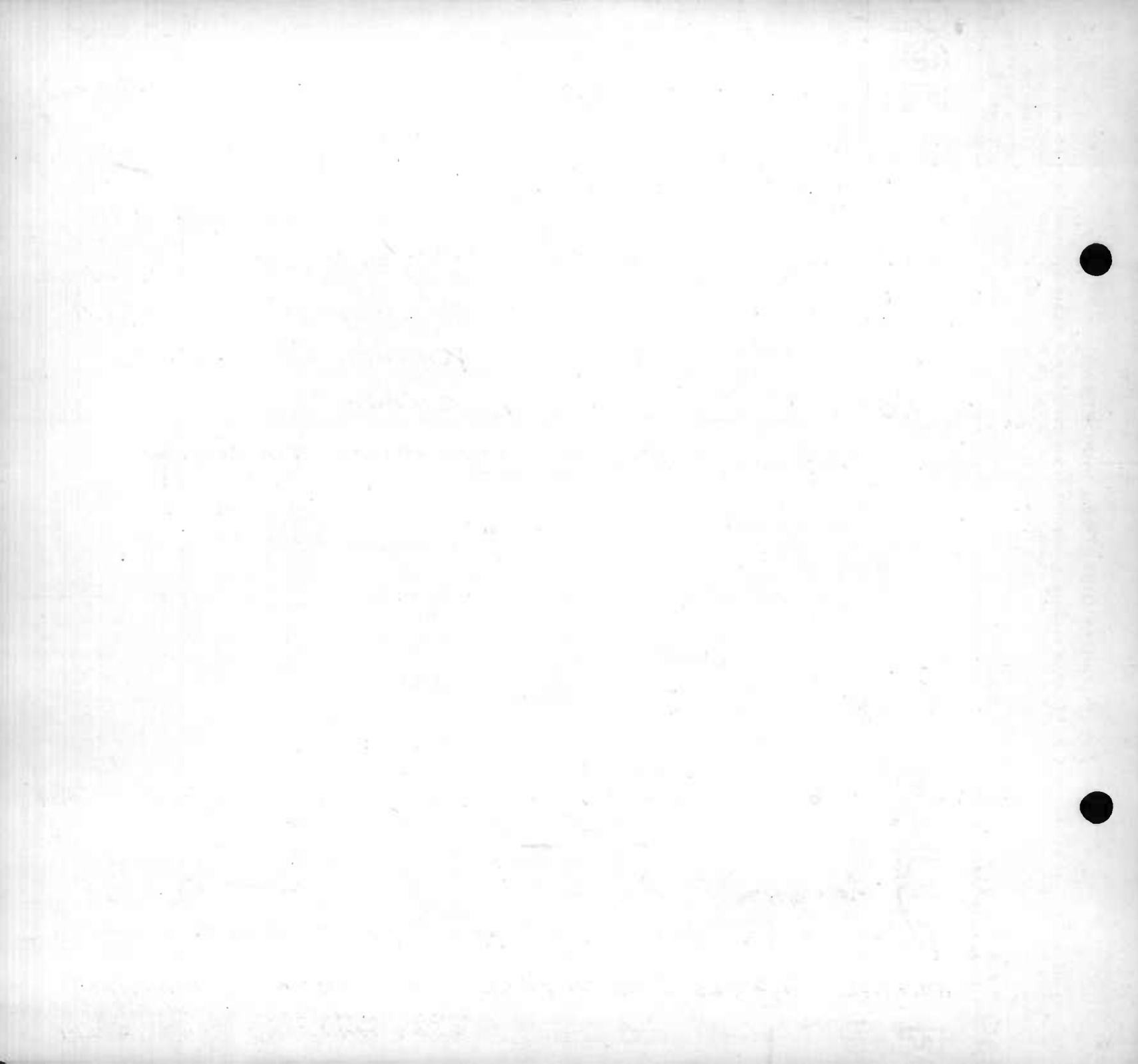
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
K-560 68- 6604 CERTIFICATE OF DEATH					REG. NO. 68- 6604						
1. NAME OF DECEASED (Type or Print) EDWIN KEEHNER					2. DATE AND HOUR OF DEATH 6/23/68 7:30pm M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL					A. STATE MARYLAND		B. COUNTY		C. CITY OR TOWN BALTIMORE		
					D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3006 WOODRING AVE.				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/15/01 67		9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REVEREND	
11. BIRTHPLACE (State or foreign country) BALTIMORE					12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME JOHN KEEHNER					14. MOTHER'S MAIDEN NAME KATHERINE FRITZ						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 212-36-0000		17. INFORMANT ADDRESS				
18. CAUSE OF DEATH 410.9 I ACUTE MYOCARDIAL INFARCTION.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II											
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/20 1968 to 6/23 1968 , that (we) lost saw the deceased alive on 6/23 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. Grossman / SIERRA					23B. DATE SIGNED 6/23/68						
23C. PHYSICIAN'S NAME (Type) JOSHUA GROSSMAN M.D.					23D. ADDRESS MARYLAND GENERAL HOSPITAL						
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK CEM.			24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fisher			25C. FUNERAL DIRECTOR ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 HARFORD ROAD 21214						



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6605
BIRTH NO. M-620		68-6605		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Robert Morrissey		2. DATE AND HOUR OF DEATH 6-23-68 4:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore Inc		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 115 Smithwood Ave		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1956	9. AGE (In years last birthday) 12 years
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William R Morrissey		
14. MOTHER'S MAIDEN NAME Celine M. Pepler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT W R Morrissey-115 Smithwood Ave		
18. 746.1 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Possible Cerebral Thrombosis		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Polythemia DUE TO, OR AS A CONSEQUENCE OF: Cyanotic		
(C) Long Heart Disease - AV Canal		12 yrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Down's Syndrome				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (A) (this hospital) attended the deceased from JUNE 20 1968 to JUNE 23 1968 , that (I) (we) last saw the deceased alive on JUNE 23 1968 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E H Loyal M.D.				23B. DATE SIGNED June 23, 1968
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-26-1968		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) Baltimore -- Maryland		(State)		
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Edwin M. Taylor 3017 Redwood Rd - 78

William R. Manning
 Student
 112 South Street
 4-10-12 12 years
 W. R. Manning
 112 South Street
 4-10-12 12 years

[Faint, mostly illegible handwriting in the middle section of the page, possibly containing a list or notes.]

FUNERAL DIRECTOR: IMPORTANT

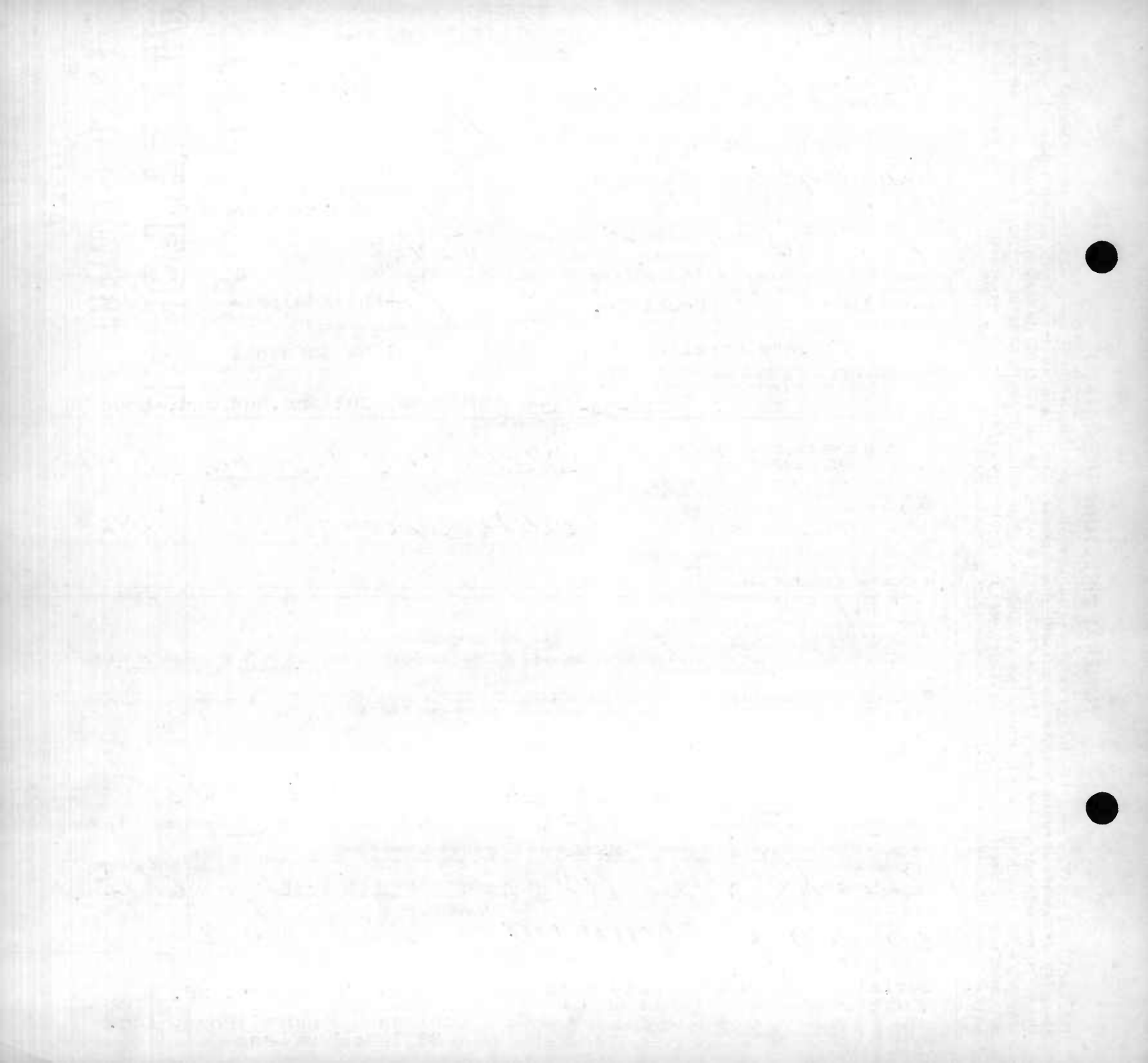
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-400 68- 6606 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 68- 6606
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) Olmstead NATALIE E. COLE		2. DATE AND HOUR OF DEATH JUNE 25, 1968 10:00 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BEE AIR Harford Co. C. CITY OR TOWN BEL AIR D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 16 East BROADWAY 62-32
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Homemaker
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME George Henry Holcomb		14. MOTHER'S MAIDEN NAME BLANCHE OLMSTED DAVIDSON
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 054-38-8319
17. INFORMANT (Son) 838-3050 or 6494 ADDRESS REV. LEWIS F. COLE, Jr. 16 East Broadway BEL Air, Maryland 21014		
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) CEREBRO VASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: (C) _____
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from June 6 19 68 to June 25 19 68 , that (I) (we) last saw the deceased alive on June 25, 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Ephraim Barzaga		23B. DATE SIGNED 6-25-68
23C. PHYSICIAN'S NAME (Type) Ephraim B. BARZAGA		23D. ADDRESS CHURCH Home & Hospital
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE JUNE 28, 1968	24C. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery
24D. LOCATION (City, town, or county) (State) Northville, Fulton Co., New York		
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fairbank
25C. FUNERAL DIRECTOR Joseph William Foster ADDRESS W. Broadway & Williams St. BEL Air, Maryland 21014		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6607</u>
J-450		68-6607		CERTIFICATE OF DEATH
BIRTH NO. <u>5-450</u>		1. NAME OF DECEASED (Type or Print) <u>JULIANO, ELEANOR P.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>6/25/68</u> <u>8:45</u> P.M.		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp of Balto.</u> <u>42</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>Edgecombe</u> <u>2847</u> XXXXXXXXXX <u>CIRCLE</u> S.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		8. DATE OF BIRTH <u>5/27/07</u> 9. AGE (In years last birthday) <u>61</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>Hecht Co.</u>		11. BIRTHPLACE (State or foreign country) <u>PA Philadelphia</u>		
13. FATHER'S NAME <u>Alfonse Perella</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Adelina Bufaroli</u>		
16. SOCIAL SECURITY NO. <u>213-03-9563</u>		17. INFORMANT <u>Michael Juliano, husband, above</u>		
18. <u>200.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>LYMPHOCYTIC LEUKEMIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>LYMPHOCYTIC LEUKEMIA</u> (B) <u>LYMPHOSARCOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mos</u> <u>1 yr</u>				
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>200.1 II</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> 19 <u>68</u> to <u>6/25</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/21</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Edward R Cohen MD</u> DEGREE		23B. DATE SIGNED <u>6/25/68</u>		23C. PHYSICIAN'S NAME (Type) <u>EDWARD R COHEN MD</u> DEGREE
23D. ADDRESS <u>Sinai Hosp</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>
24D. LOCATION <u>Baltimore, Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6609	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) BERNARD E. ECKERT		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> June 24, 1968 6:30 p. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3530 Chesterfield Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 3530 Chesterfield Ave.			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/08	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of Education		10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Bernard E. Eckert			
14. MOTHER'S MAIDEN NAME Marie Rose Treffe		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 219-03-2462		17. INFORMANT Carmella Riggi Eckert, wife, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C-V-disease (C)			
19. DATE OF OPERATION 4/20/11		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/11 1967 to 8/24 1968 that (I) (we) last saw the deceased alive on 6/11 1968 and that in (my) (our) opinion death occurred on the date 8/24 1968 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE L. B. Stevens		23B. DATE SIGNED 6/26/68		23C. PHYSICIAN'S NAME (Type) Dr. L. B. Stevens	
23D. ADDRESS 3400 Erdman Ave.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home Inc.	
25D. ADDRESS 63331 Brehms Lane					

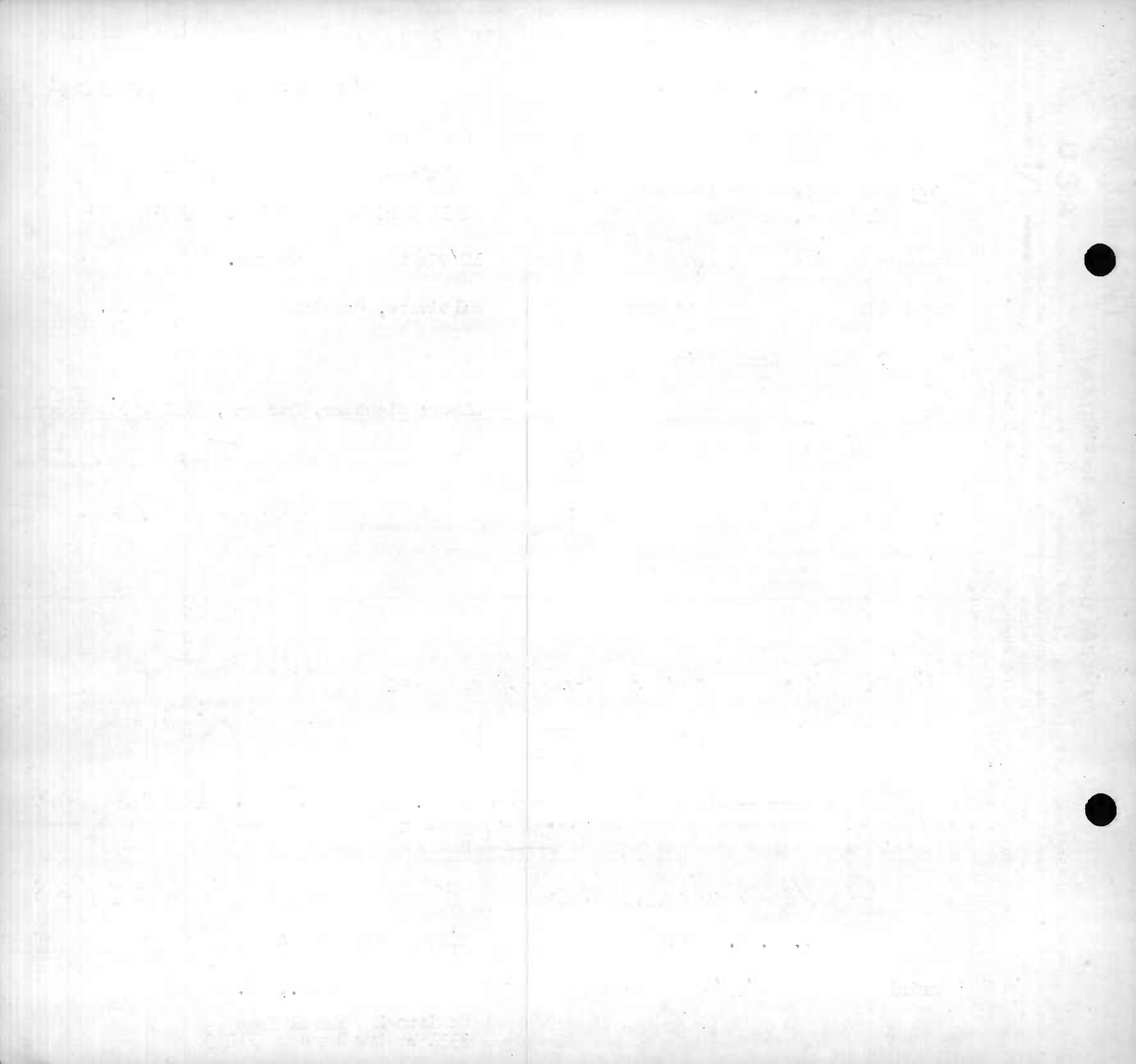
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6609
E-263 68-6609				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		BERNARD E. ECKERT		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3530 Chesterfield Ave.		June 24, 1968 6:30 p. M.		
		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Md.		
5. SEX male		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Dept. of Education		8. DATE OF BIRTH 12/25/08
13. FATHER'S NAME Bernard E. Eckert		14. MOTHER'S MAIDEN NAME Marie Rose Treffe		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-03-2462		17. INFORMANT Carmella Riggi Eckert, wife, above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic C-V-disease DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 9/16 1967 to 6/24 1968, that (I) (we) last saw the deceased alive on 6/1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Dr. L. B. Stevens		23B. DATE SIGNED 6/26/68		23C. PHYSICIAN'S NAME (Type) Dr. L. B. Stevens
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home Inc. 3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6610
BIRTH NO. 5-423		68- 6610		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Gertrude M. Slechter			2. DATE AND HOUR OF DEATH June 23, 1968 10.30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2811 Christopher Avenue Baltimore, Maryland 21214			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2811 Christopher Avenue 21214		
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/08	9. AGE (In years last birthday) 59 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME 1 Rosenstien		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO.			17. INFORMANT Albert Slechter, husband, 2811 Christopher Ave. 21214		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH General carcinomatosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma, uterus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 18 months		
19A. DATE OF OPERATION 174X II 0 Mar '68			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intest. obstruction		
20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19 67 to June 23 1968, that (I) (we) last saw the deceased alive on June 21 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. M. Bacon, M.D.			23B. DATE SIGNED 6/26/68		
23C. PHYSICIAN'S NAME (Type) Dr. A. M. Bacon			23D. ADDRESS 2810 Taylor Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME of CEMETERY or CREMATORY Moreland Memorial	
24D. LOCATION Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Schironek Funeral Home		25D. ADDRESS 3331 Brehms Lane		25E. ADDRESS 21213	



L-260

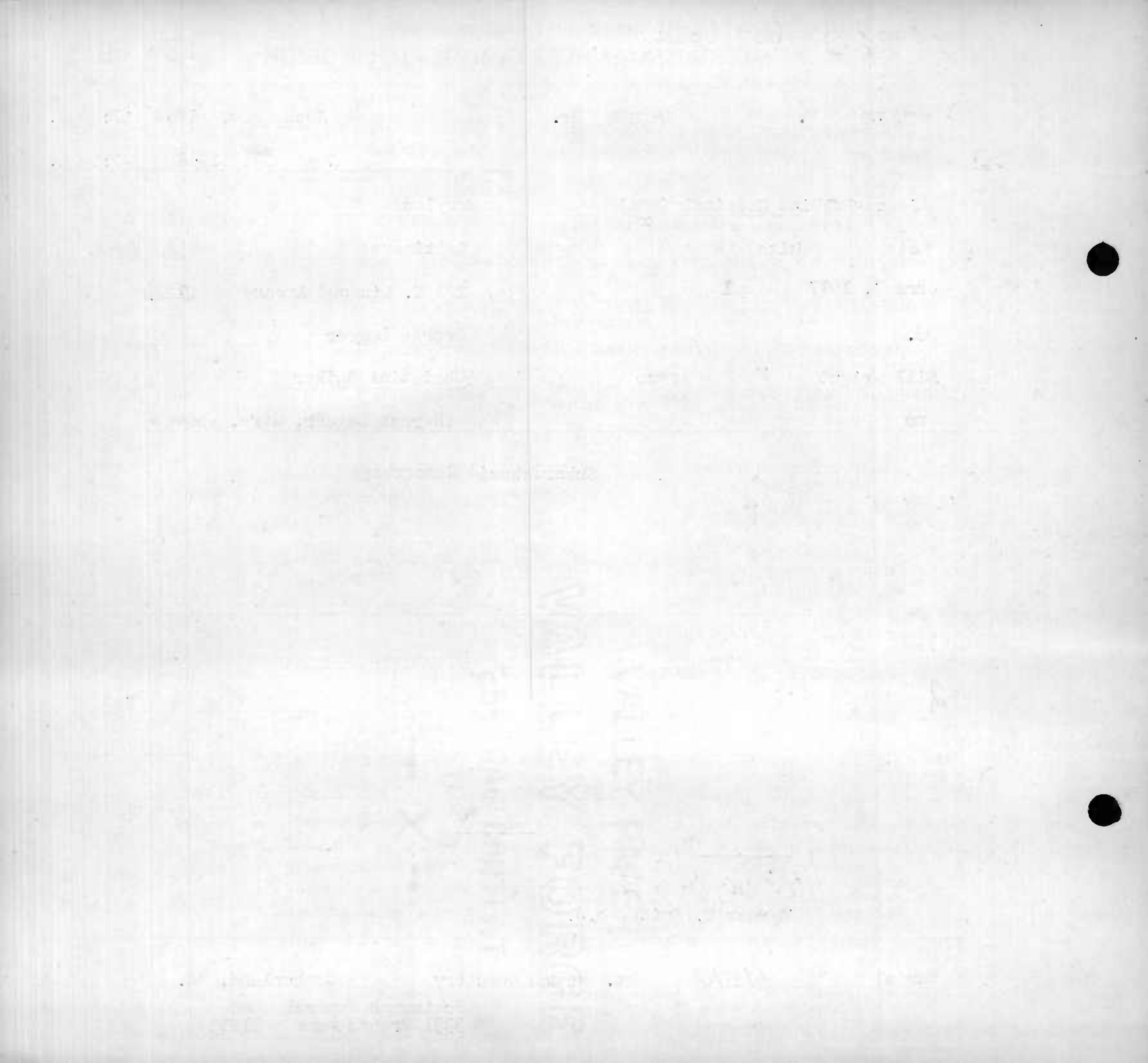
68-6611 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6611

BIRTH NO.

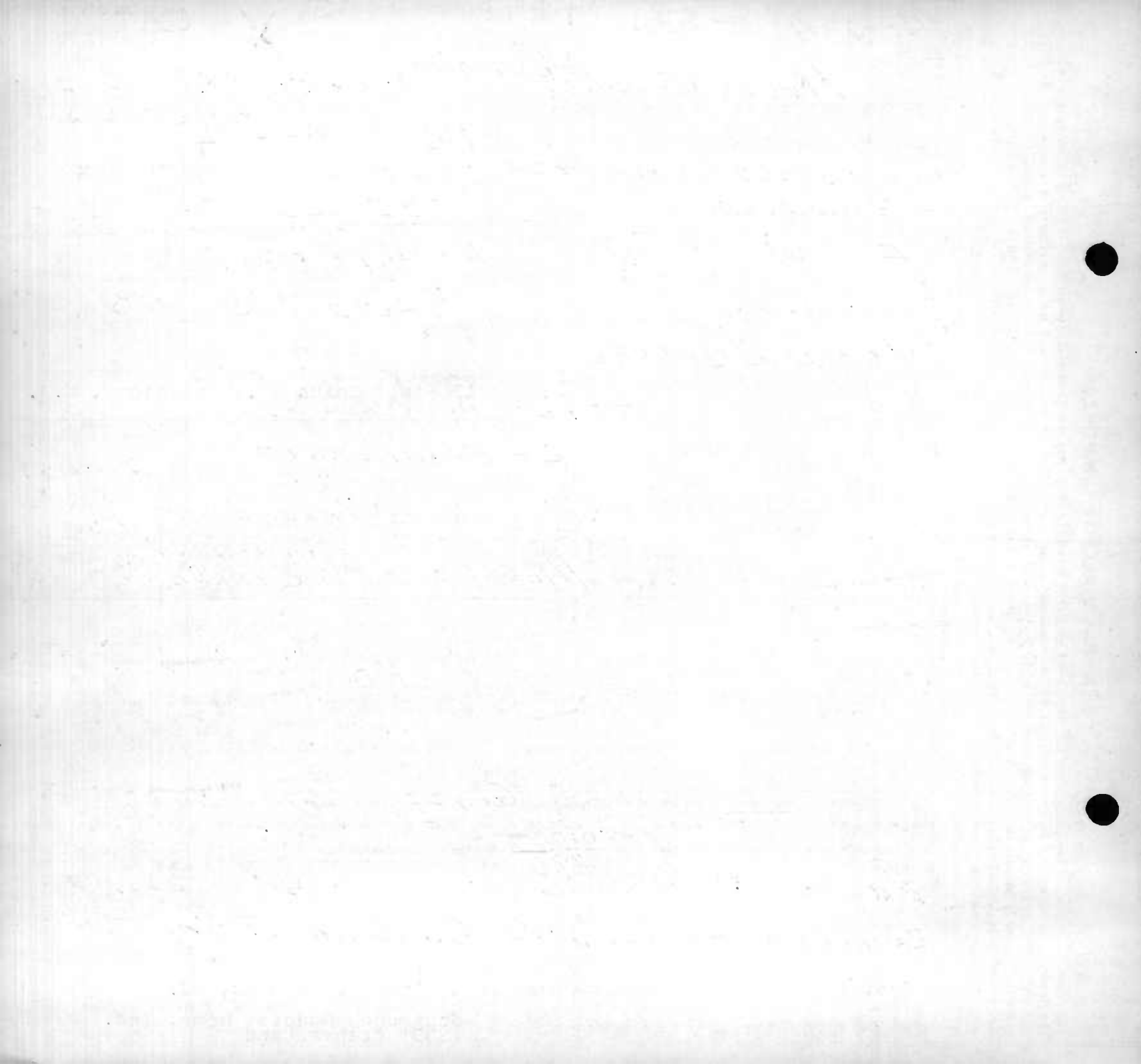
1. NAME OF DECEASED (Type or Print) WILLIAM F. LEGER Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 24, 1968 7:00 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1968 7:10 A.M.	
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore
9. DATE OF BIRTH June 7, 1917	10. AGE (In years lost birthd.) 51	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? George Legeer
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright		14B. KIND OF BUSINESS OR INDUSTRY Armco	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Christina Spiker		18. INFORMANT Theresa Legeer, wife, above	
19. 4309 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 330X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6/24/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/27/68	24C. NAME of CEMETERY or CREMATORY Mt. Herman Cemetery	24D. LOCATION (City, town, or county) (State) Cumberland, Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR Robert E. Finkbeiner	25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 3331 Brehms Lane 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-532 68-6612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6612	
CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) MAUDE MARGARET MONTGOMERY					
2. DATE AND HOUR OF DEATH JUNE 23, 1968 6 P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO STATE HOSP BALTO, MD.			A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN BEL AIR. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 305 LOCUST LANE.		
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27, 1914	9. AGE (In years last birthday) 73.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESWOMAN.			11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JOHN DRESSEL			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-05-8292		17. INFORMANT FOSTER DAUGHTER. ADDRESS 12 Stage Coach Rd., Vincenttown, N.J. ANNA HATHIUS.
18. 433,01 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			RT. HEMIPLEGIA.		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL THROMBOSIS.		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) HYPERTENSIVE VASCULAR DISEASE. 10+ yrs.		
332X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 22 1967 to June 23 1968, that (I) (we) lost saw the deceased alive on June 23 1968 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond W. Herrmann M.D.			23B. DATE SIGNED 6/23/68		
23C. PHYSICIAN'S NAME (Type) RAYMOND W. HERRMANN, M.D.			23D. ADDRESS Montebello St. Hosp Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/26/68	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6613

BIRTH NO. 64-23127

1. NAME OF DECEASED (Type or Print) BARABARA HARRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968 Hour 9:20 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Cellar - 926 Whatcoat Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 22, 1968 9:20 A. M.	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8.18.1964		10. AGE (In years last birthday) 3 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E966X		CAUSE OF DEATH Axe wound of Head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Cellar	
22D. TIME OF INJURY (APPROX.) 6 22 68 A. M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Axe wound of head		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 926 Whatcoat Street 16-02	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6.24.1968	
24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR Lindsey H. Currell		25D. ADDRESS 1529 E. North Ave. City	

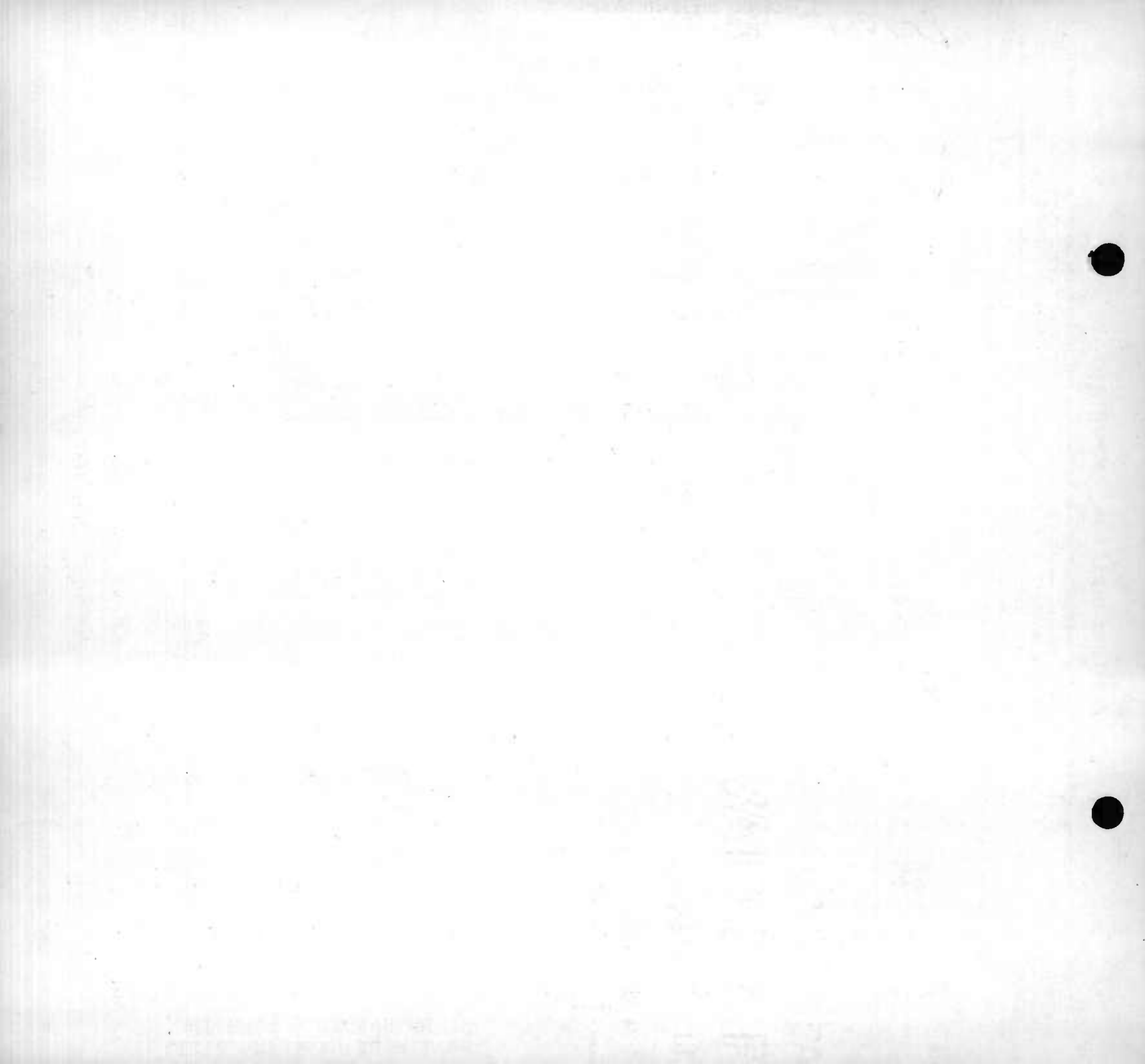
James M. Thompson
Frank H. Jones
Frank H. Jones

WALTER B. BOWEN
WALTER B. BOWEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

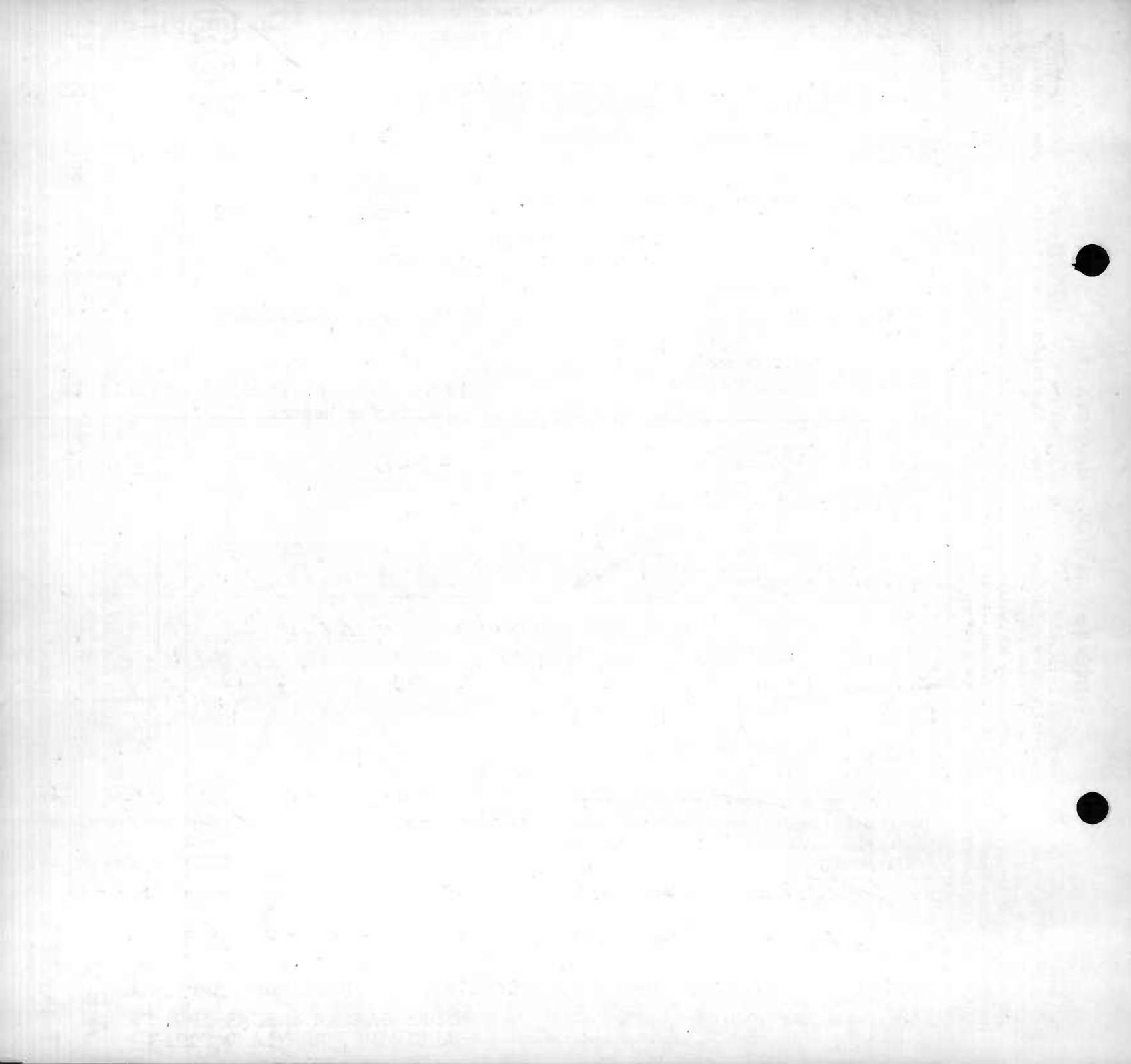
B-100		68- 6614		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 6614						
BIRTH NO.					1. NAME OF DECEASED (Type or Print) (CHARLOTTE MAY BUBB)					2. DATE AND HOUR OF DEATH JUNE 25, 1968 6: 45 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY					C. CITY OR TOWN BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX F					6. RACE W					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH 3/31/80					9. AGE (In years lost birthday) 88					If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10B. KIND OF BUSINESS OR INDUSTRY Housewife					11. BIRTHPLACE (State or foreign country) MARYLAND				
12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME AMOS HULL					14. MOTHER'S MAIDEN NAME ALBERTA SCHULER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 217-48-8504					17. INFORMANT Mrs Mildred V. Westerman DAUGHTER 3817 Kimble Road				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS					19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if only going rise to the above cause (A) sliding the UNDERLYING CONDITION lost. MYOCARDIAL INFARCTION MONTHS FRACTURED HIP MONTHS				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). SEVERE DECUBITUS ULCERS MONTH					20. DATE OF OPERATION NONE					21. CONDITION FOR WHICH OPERATION WAS PERFORMED				
22. DATE OF OPERATION NONE					23. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) NURSING HOME					24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2401 EUTAW PLACE				
25. TIME OF INJURY (Month) (Day) (Year) (Hour) 5/4/68 ?					26. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>					27. HOW DID INJURY OCCUR? FELL OFF HER BED				
28. I certify that (I) (this hospital) attended the deceased from 5/4/68 to 6/25/68 and that (I) (we) last saw the deceased alive on 6/25/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					29. SIGNATURE Charles M. Harrison M.D.					30. DATE SIGNED 6/25/68				
31. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON M.D.					32. ADDRESS MARYLAND GENERAL HOSPITAL					33. DATE REC'D BY HEALTH DEPT. JUN 27 1968				
34. NAME OF REGISTRAR Robert E. Taylor					35. FUNERAL DIRECTOR HENRY SANDER & SONS INC.					36. ADDRESS BALTIMORE MARYLAND 21213				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 1280 68- 6615
D-400 68- 6615		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		PAUL, RUTH C. (KATHERINE RUTH PAUL)		
2. DATE AND HOUR OF DEATH		6-24-68 1:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		
Baltimore Hill Nursing & Convalescent Ctr.		C. CITY OR TOWN Baltimore		
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX F		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 10-14-83
Home Maker				9. AGE (In years last birthday) 84
13. FATHER'S NAME Paul, George		14. MOTHER'S MAIDEN NAME Wise, Margaret		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 54 2298		12. CITIZEN OF WHAT COUNTRY? U.S.A.
NO				17. INFORMANT Miss Nellie H. Paul 11 Bayship Rd Admission Record
18. 412.3 IV-230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo. +
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II Diabetes Mellitus				?
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5/17 1968 to 6/24 1968, that (I) (we) last saw the deceased alive on 6/22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.				
23A. SIGNATURE Stephen Toms, MD		23B. DATE SIGNED 6/24/68		23C. PHYSICIAN'S NAME (Type) Stephen Toms, MD
23D. ADDRESS 1712 WINFORD RD		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Sander		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC. BALTIMORE, MARYLAND 21213



68- 6616

BALTIMORE CITY HEALTH DEPARTMENT

68- 6616

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN Michael YOUNG		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968 Hour 1:10 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1968 Hour 1:10 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-02		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11/27/1949	10. AGE (In years lost birthday) 18	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME John H. Young	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		14B. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co.	
15. MOTHER'S MAIDEN NAME Dorothy Will		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 219-50-0182		18. INFORMANT John H. Young ADDRESS -810 N. Carey Street	
19. 304.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous Narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: June 22, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		ADDRESS	

Paul H. Keller

1
S-156

68- 6617

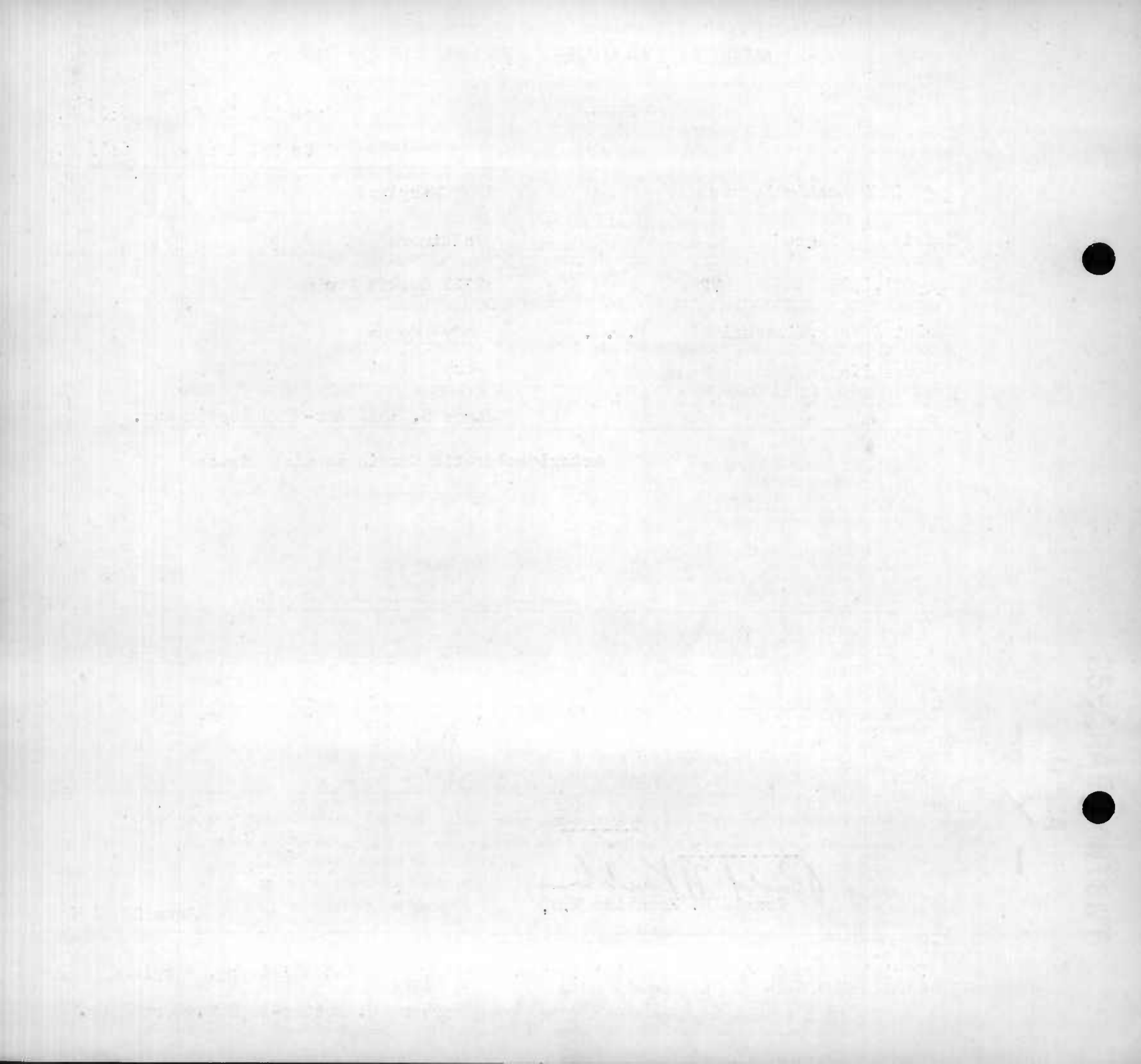
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6617
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAHATA SHOFFNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 23, 1968 6:35 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2222 Ruskin Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1968 6:35 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 31, 1895		10. AGE (In years lost birthday) 73	
11. BIRTHPLACE (State or foreign country) Saint Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
15. MOTHER'S MAIDEN NAME Mary ? ?		13. FATHER'S NAME Andy Hogue	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT James H. Shoffner-2222 Ruskin Ave.		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Minute)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 23, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/68	
24C. NAME of CEMETERY or CREMATORY Saint Thomas Cemetery		24D. LOCATION (City, town, or county) (State) Randallstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) George Morris		2. DATE AND HOUR OF DEATH June 22 1968 10 50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-04			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 469 Walton Court 21201					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-99 69	AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper		10B. KIND OF BUSINESS OR INDUSTRY Paint Company		11. BIRTHPLACE (State or foreign country) Gloucester Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME GEORGE John Morris		14. MOTHER'S MAIDEN NAME CATHERINE JONES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-07-4250		17. INFORMANT ADDRESS Lela Summerville-463 Walton Court	
18. 412.131 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction 10yr (B) Severe ASCVD + renal failure 20yr DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19 1968 to 6/22 1968 , that (I) (we) last saw the deceased alive on 6/22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas C. Butler		23B. DATE SIGNED 6/23/68		23C. PHYSICIAN'S NAME (Type) THOMAS C. BUTLER M.D.	
23D. ADDRESS 601 N. Broadway					
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6619	
NICHOLSON, MAMIE E.				JUNE 22, 1968 9:35 P. M.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		20-06.	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229		A. STATE MARYLAND 21229		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3 S. ABINGTON AVE.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-1921	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MESS ATTENDANT		10B. KIND OF BUSINESS OR INDUSTRY KIMBROUGH HOSP		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALPHONSO GATEWOOD		14. MOTHER'S MAIDEN NAME ELESTINE SIMMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AVES. BALTO MD. 21229 ST. AGNES RECORDS- WILKENS & CATON	
18. 197.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Metastatic Lesion in Liver.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>exploratory laparotomy & Liver biopsy at 6-13-68</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 156.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 9 1968 to JUNE 22 1968, that (X) (we) last saw the deceased alive on JUNE 22 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Hamid</i>		23B. DATE SIGNED 6-22-68		23C. PHYSICIAN'S NAME (Type) DR. HAMID M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/68		24C. NAME OF CEMETERY OR CREMATORY Saints Rest Cemetery	
24D. LOCATION (City, town, or county) (State) Harmons, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>	
25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6620	
BIRTH NO. 67-24540 68-6620					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MARK ARTHUR CURTIS			21 June 68 9:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
38 Univ Hosp., Balt., Md.			Md BALT CITY 20-07		
E. STREET AND NUMBER			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3927 West Mulberry ST., Balt., Md.			F. DATE OF BIRTH		
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			11/30/67 6 mos. 6 21		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
- child None			Balt., Md		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Albert Curtis			Alice Wise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			-		Hosp Chart
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
247.01			Cardiovascular Collapse		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Banding of Prim. Art.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
Post op Ligation of PPA			(C) Congenital Heart Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
754.1 II			none.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20 June		Pat. Ductus Art + VSD		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-	
22. I certify that (I) (this hospital) attended the deceased from 6-4-68 19 to 21 June 68, that (I) (we) last saw the deceased alive on 21 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. M. Anderson				21 June 68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
C. M. Anderson				Univ. Hosp Balt., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/26/68		Baltimore National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 27 1968		Robert E. Taylor		Herbert E. Nutter-3035 W. North Ave.	

100-100000

W/100

100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

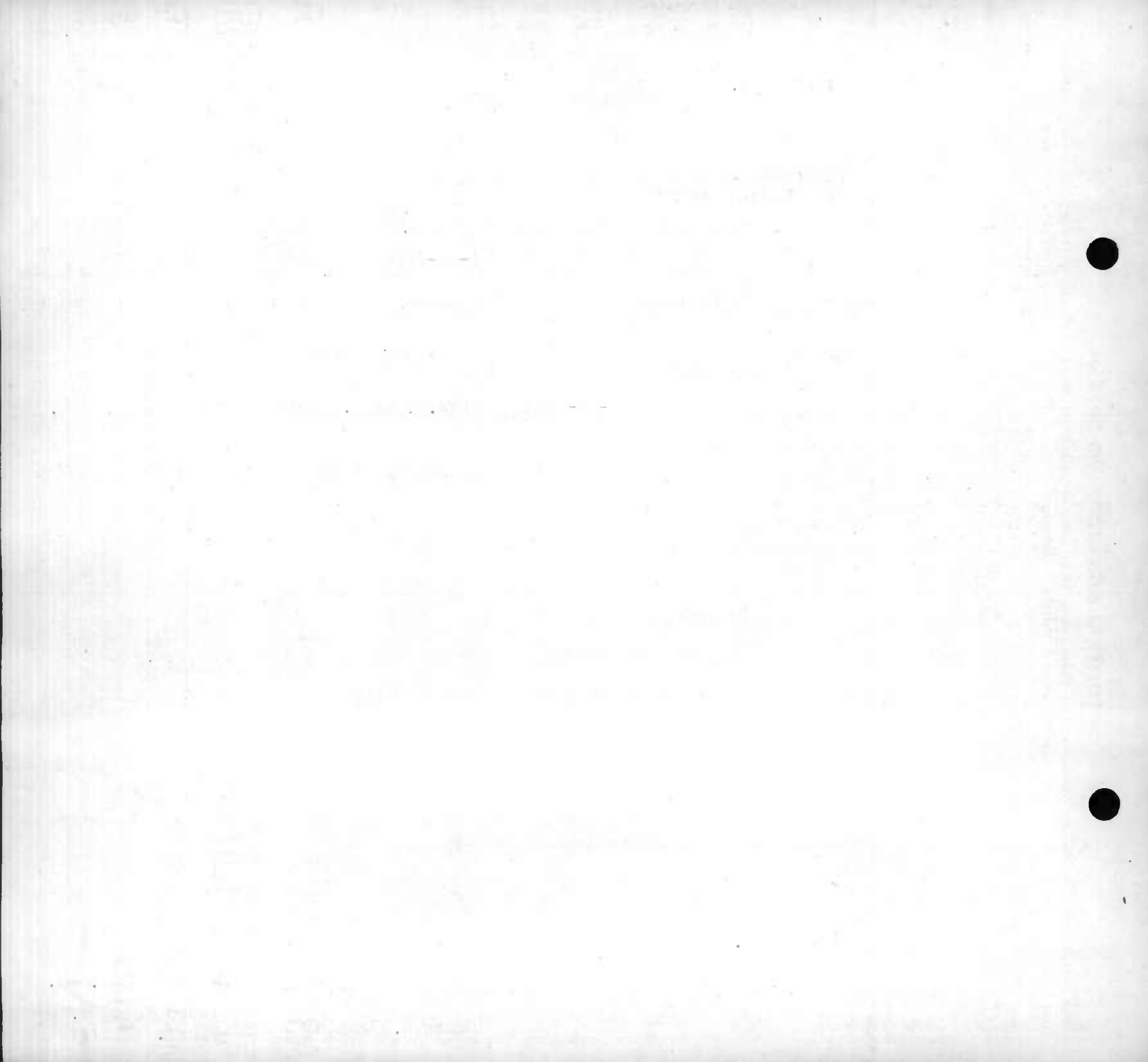
REG. NO. 68- 6621

BIRTH NO. 68- 6621		2. DATE AND HOUR OF DEATH June 26, 1968 1:25 PM	
1. NAME OF DECEASED (Type or Print) Eddie Edwards		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 304 E Lanvale Street 21202	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital 4940 Eastern Ave., Balto., MD. 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-22-14
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54 11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas		14. MOTHER'S MAIDEN NAME Malissia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave., Balto., MD.		ADDRESS	
18. 011-971303-2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hemoptysis due to pulmonary tuberculosis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 3 1/4 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 002.1 II Chronic alcoholism many yrs			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17 1968 to 6/26 1968, that (I) (we) last saw the deceased alive on 6/25/ 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Mary Ann Sullivan		23B. DATE SIGNED 6/26/68	
23C. PHYSICIAN'S NAME (Type) Mary Ann Sullivan		23D. ADDRESS Baltimore City Hospitals 21224 4940 Eastern Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/29/68	24C. NAME OF CEMETERY or CREMATORY Mt. Zion	24D. LOCATION (City, town, or county) (State) Chattam Co. N.C.
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR J. B. Johnson 1900 Eastern Pl. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

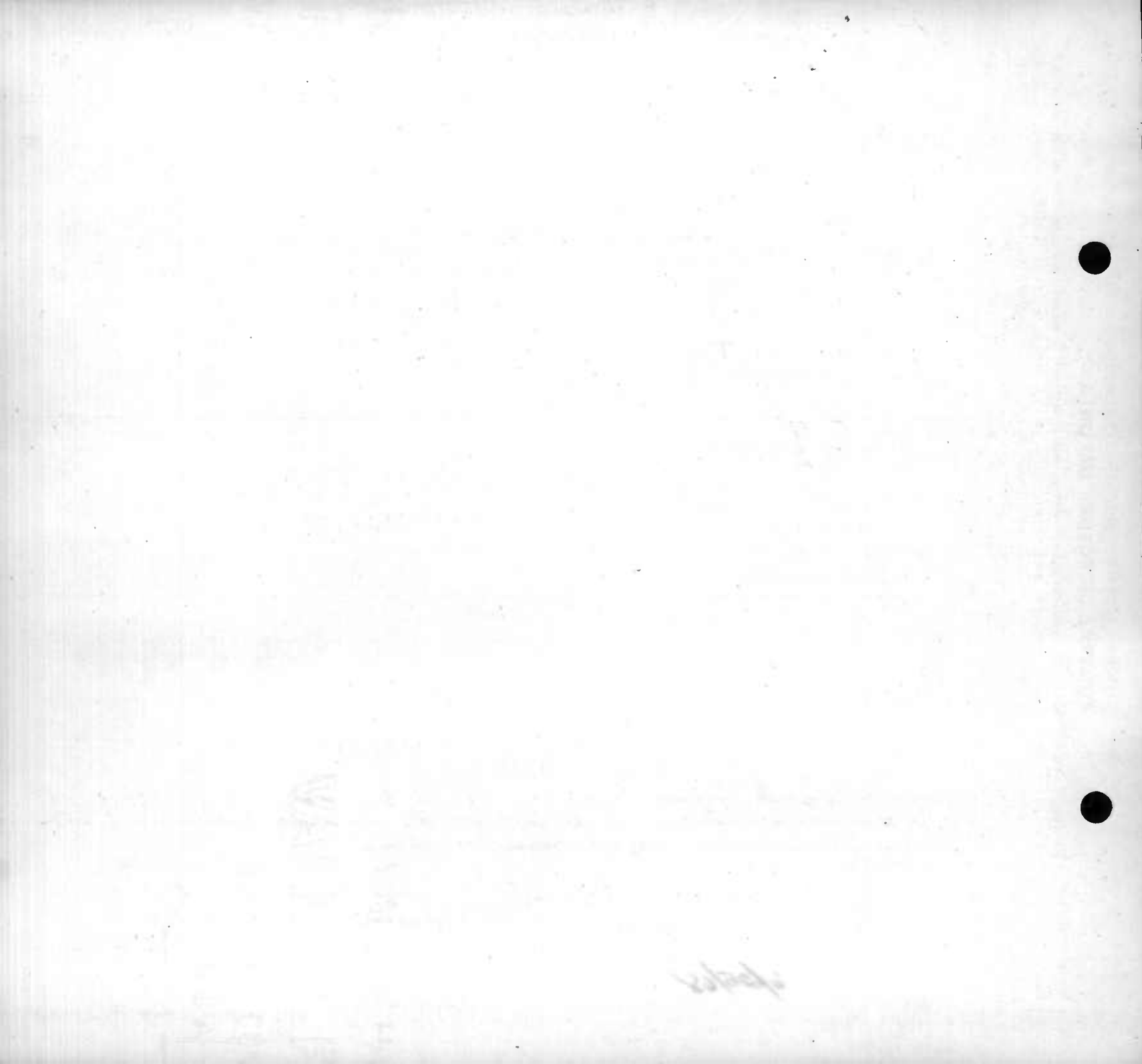
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6622	
<div style="display: flex; justify-content: space-between;"> J-525 68-6622 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <i>Elizabeth S. Johnson</i>		2. DATE AND HOUR OF DEATH <i>6/26/68</i> <i>1:45</i> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Taylor Home 4608 Roland Avenue</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3405 Greenway</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-24-1884</i>	9. AGE (In years lost birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Shaughnessy</i>			
14. MOTHER'S MAIDEN NAME <i>Elizabeth Keefe</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>238-30-6018</i>		17. INFORMANT <i>Mrs. Lynn D. Poole</i>			
ADDRESS <i>3405 Greenway, Balto</i>					
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><i>412.4 I</i></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intoxic alcohol C.V. Disease</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>? yrs</i>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/17/68</i> 19 to <i>6/26/68</i> 19 that (I) (we) last saw the deceased alive on <i>6/25/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Francis W. Gluck</i>		23B. DATE SIGNED <i>6/26/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Francis W. Gluck</i>	
23D. ADDRESS <i>100 W University Pkwy</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>June 26, 1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>Green Mount Crematory</i>	
24D. LOCATION <i>Greenmount & Oliver</i>		24E. (City, town, or county) (State) <i>Balt. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 27 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Henry W. Jenkins & Sons</i>	
ADDRESS <i>4905 York Rd. Balt. Md 21212</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6623 4
T-520 68- 11259 68- 6623		CERTIFICATE OF DEATH			
BIRTH NO. 68- 11259		1. NAME OF DECEASED (Type or Print) BABY GIRL THOMAS.			
2. DATE AND HOUR OF DEATH 6.21.68.		6.12. P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL OF MARYLAND.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2717 W. MOSHER STREET.			
5. SEX FEMALE	6. RACE NEGRO.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.21.68.	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN C. THOMAS		14. MOTHER'S MAIDEN NAME CAROLYN L. THORN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 759.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: i) GROSS Congenital anomalies. ii) PREMATUREITY.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 75-9.3 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6.21.68 to 6.21.1968, that (we) last saw the deceased alive on 6.21.1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. Sheereen M.D.		23B. DATE SIGNED 6.21.68.		23C. PHYSICIAN'S NAME (Type) SHEREEN SHEIKH	
23D. ADDRESS LUTHERAN HOSPITAL, BALTO., MD.		23E. ADDRESS MORTUARY SERVICE - BCHD			
24A. BURIAL CREMATION, REMOVAL (Specify) 6/25/68		24B. DATE 6/25/68		24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION (City, town, or county) BALTO., MD.		24E. LOCATION (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6624	
A-425 68- 6624		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ALEXANDER, JANE ISABELL		JUNE 26 1968		3:45P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
		MARYLAND			
ST AGNES HOSP. CATON & WILKENS AVE BALTO MD 21229		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		13 MONUMENTAL ROAD		63-00	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	07 05 10	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN VICTOR Alexander		ROSE (TOMS)		U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				ST AGNES RECORDS-CATON & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Intracranial hemorrhage.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 25 19 68 to JUNE 26 19 68, that (IX) (we) lost saw the deceased alive on JUNE 26 19 68 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Korbuly		06 26 68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. KORBULY		BALTO MD 21229 ST AGNES HOSP. CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)	
burial	6/29/68	Greenhill Cemetery	Waynesboro,	Pa.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 27 1968	Robert E. Salter	Gladhill Company, Middletown, Md.			

DATE: 10/10/50

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

(10/10/50)

[illegible]

ST. LOUIS (100-100000)

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

10/10/50

ST. LOUIS (100-100000)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6625	
B-626 68- 6625 BIRTH NO. 68-10920 1. NAME OF DECEASED (Type or Print) Brazier, Baby of Loretta				2. DATE AND HOUR OF DEATH June 14, 1968 7:53 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc.				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1035 Argyle Avenue	
5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-68 9. AGE (In years last birthday) 5 If Under 1 Yr. Months Days 5 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minor 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Loretta Brazier ADDRESS SAME	
18. 772.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecefesin Penicillin ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hemorrhage in basal Ventricul Prematurity				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (naffy medical examined)		21B. PLACE OF INJURY (e.g., in a about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 14, 1968 to June 14, 1968 , that (I) (we) lost saw the deceased alive on June 14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antonio C. Santos, M.D. 23C. PHYSICIAN'S NAME (Type) Antonio Santos, M. D.				23B. DATE SIGNED 6-17-68 23D. ADDRESS 1514 Division Street Balto., Maryland 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) 6/25/68		24B. DATE 6/25/68		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL 24D. LOCATION MORTUARY SERVICE - BCHD	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS	

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Handwritten text, mostly illegible due to fading. Some words like "and" and "the" are visible.

Handwritten text, mostly illegible due to fading. Some words like "the" and "of" are visible.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6626 7	
C-160 68- 6626		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby GIRL COVER		2. DATE AND HOUR OF DEATH 6/21/68 9⁰⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 819 W. 35th STREET	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) —
13. FATHER'S NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	17. INFORMANT SUSAN LEE COVER
18. 778.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) PREMATURITY DUE TO, OR AS A CONSEQUENCE OF: (C) W.K.W.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-21-1968 to 6-21-1968 , that (I) (we) lost saw the deceased alive on 6-21-1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23B. DATE SIGNED 6-21-68	
23A. SIGNATURE D.H. BRANCATO, M.D.		23C. PHYSICIAN'S NAME (Type) D.H. BRANCATO M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 9/25/68		24B. DATE	
24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL		24D. LOCATION ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

1912

UNION MEMORIAL HOSPITAL

REAR WHITE

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BALTIMORE CITY HEALTH DEPARTMENT				68-6627			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 68-6627			
BIRTH NO. 68-12399							
1. NAME OF DECEASED (Type or Print) <u>Unidentified Newborn term xxxx infant</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>March 25, 1968 10:50 A.M.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>(Rear of) 405 Franklinton Road</u>		5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY <u>20</u>		6. SEX <u>Male</u>		7. RACE <u>W NK</u>	
8. B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH <u>Newborn</u>		10. AGE (In years lost birthday) <u>MIN</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Undetermined</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <u>8</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>Yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles S. Springate</u> EXAMINER'S NAME (Type)		M.D. <u>Charles S. Springate, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 14, 1968</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>6-21-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Medical Examiners Office</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>		ADDRESS	

1

R-163 68- 6628 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6628

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JULIA ROBERTS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 4, 1968		Hour 3:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1916 Pennsylvania Avenue		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year June 4, 1968		Hour 3:15 A.M.	
6. SEX female		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday) 56		11. BIRTHPLACE (State or foreign country)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1916 Pennsylvania Avenue		14-03	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20. 581.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/4/68			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/2/68		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or County) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

VS 151-REV. 1/1/68

4/2/64

1		68- 6629		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 68- 6629		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) WILSON W. REGESTER					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 8, 1968 11:00 A.M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1845 McHenry Street					3. DATE PRONOUNCED DEAD Month Day Year Hour June 8, 1968 4:14 P. M.					
6. SEX male					7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 19-04	
9. DATE OF BIRTH			10. AGE (In years last birthday) 80		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					14B. KIND OF BUSINESS OR INDUSTRY					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)					17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22F. HOW DID INJURY OCCUR?					23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/9/68					
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE 6/21/68					
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968					25B. NAME OF REGISTRAR Robert E. Fairley					
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD					25D. ADDRESS					

WALTER P. HARRIS

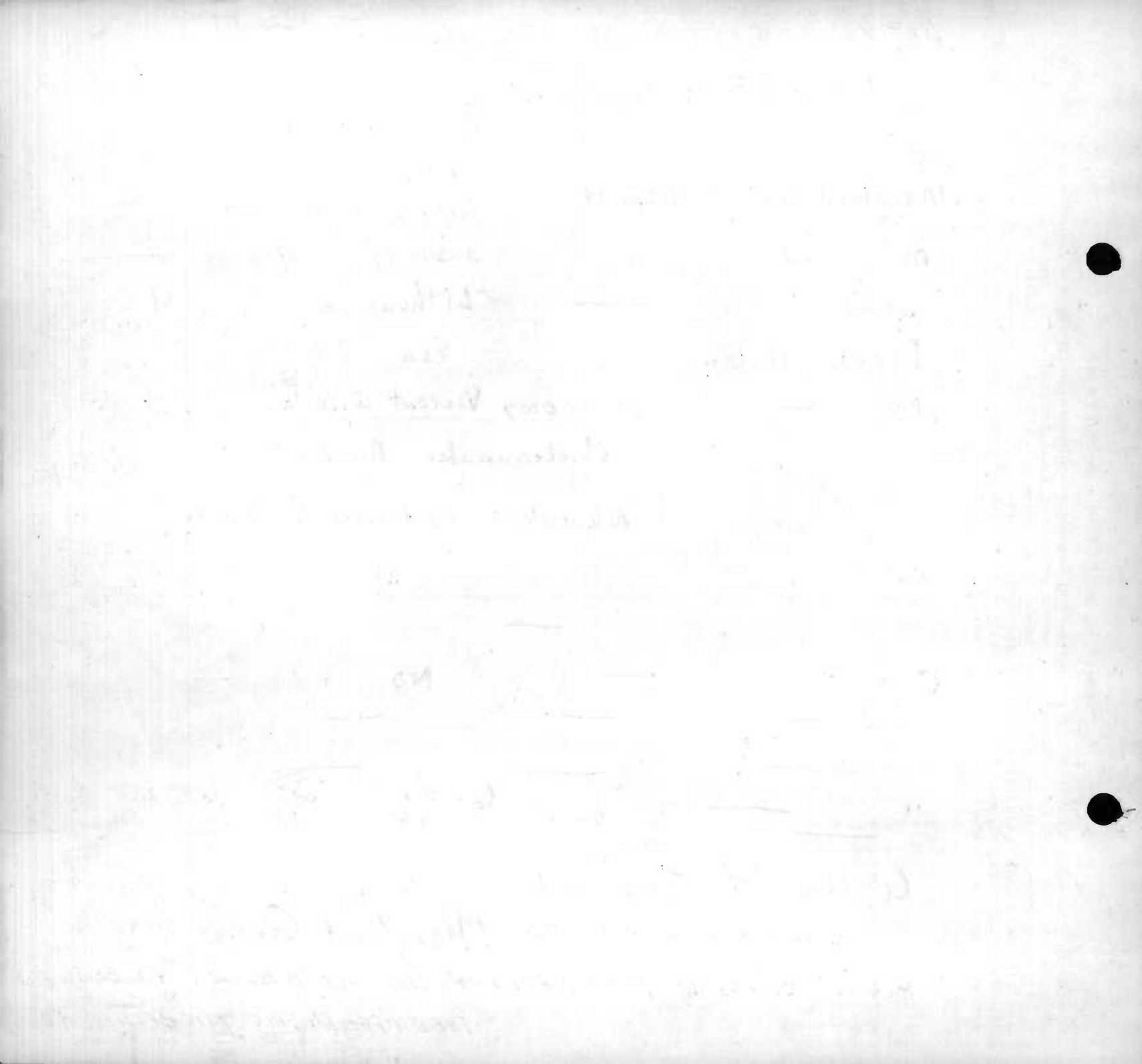
RECEIVED

4/21/98

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6630	
<div style="display: flex; justify-content: space-between;"> M-450 68- 6630 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Matthew F. Milan</u>		2. DATE AND HOUR OF DEATH <u>6-25-68</u> <u>7:15</u> <u>P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>			A. STATE <u>Maryland</u>		B. COUNTY
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>5111 Plainfield Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-24-71</u>	9. AGE (In years last birthday) <u>97</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Frank Milan</u>		14. MOTHER'S MAIDEN NAME <u>Eva ??</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-0307</u>		17. INFORMANT (Son) <u>Vincent W. Milan</u>	
				ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Accident</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Cardiovascular Disease</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>422.1 II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-1968</u> to <u>6-25-1968</u> , that (I) (we) last saw the deceased alive on <u>6-25-1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William L. Boddie M.D.</u>				23B. DATE SIGNED <u>6-25-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM L BODDIE MD</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JUNE 28 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEM</u>	
24D. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD BALTO MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>THE DIPPEL BROS INC 7110 BELAIR RD</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6631

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEONARD W. WHITE				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 26 68 8:35 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL ADDRESS OR LOCATION) CERTIFICATE AMENDED 1313 W. Baltimore St. D.O.A.				3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1968 8:35 a.m.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 43 ?				10. AGE (In years lost birthday) 43 ?			
11. BIRTHPLACE (State or foreign country) WILCO, WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPAIR TV				14B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II				17. SOCIAL SECURITY NO. 235-36-8031			
18. INFORMANT RANDOLPH WHITE				ADDRESS 1418 LIGHT ST.			
19. CAUSE OF DEATH E 980.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 970.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ingestion of dilantin, librium, phenobarbital and phenothiazine				(A) IMMEDIATE CAUSE Undetermined DUE TO, OR AS A CONSEQUENCE OF: (B) Decomposition DUE TO, OR AS A CONSEQUENCE OF: (C) Ingestion of dilantin, librium, phenobarbital, phenothiazine			
20A. DATE OF OPERATION 8				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED phenothiazine			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) ?				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Unknown			
22F. HOW DID INJURY OCCUR? Unknown				21. AUTOPSY? (Yes or No) YES			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 29, 1968		24C. NAME OF CEMETERY or CREMATORY WHITES CEM.		24D. LOCATION (City, town, or county) (State) OAKVALE RD OAKVALE W. VA.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR DIPPEL BROS INC		ADDRESS 1800 E LOMBARD ST.	

VALLEY PAPER
VALLEY FORGE

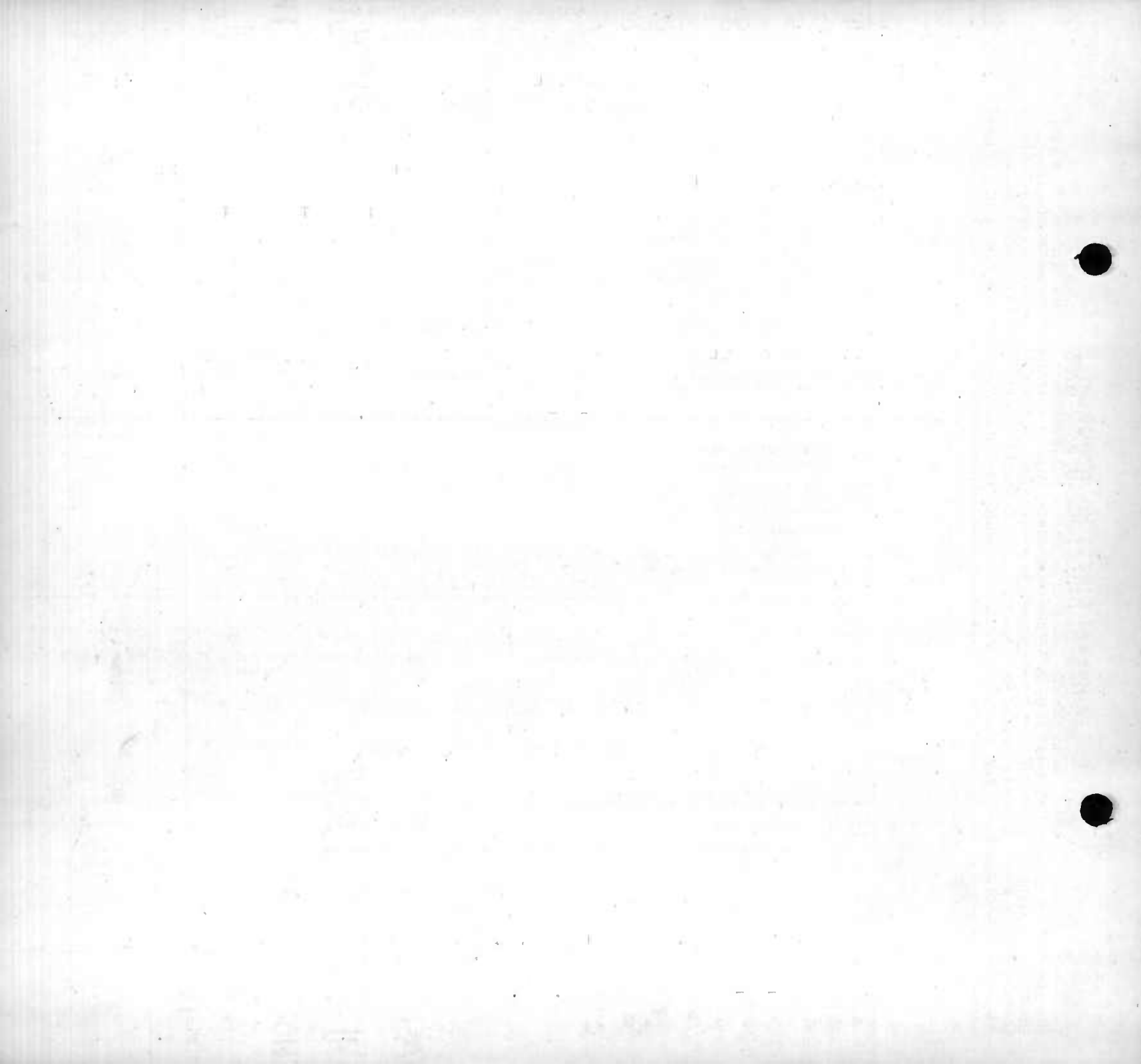
SHAG CONTENT

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-424 68-6632				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6632	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				LUTHER BLACKWELL		6-20-68 8:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1600 VINCENT COURT			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-14-87	81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Georgia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WYATT BLACKWELL				LULA Phyllis Crawford			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		213-16-5111 A		Martha O. Blackwell		1600 Vincent Ct.	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				renal failure			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				diabetic nephropathy			
				diabetes mellitus			
260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				goat - g6PD deficiency			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
15730768 16117168		diabetic gangrene					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
no							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 27 1968 to May 20 1968, that (I) (we) last saw the deceased alive on June 20 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. ADDRESS		23C. DATE SIGNED	
Thomas A. Broadie, M.D.				The Johns Hopkins Hospital		June 20, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
THOMAS A. BROADIE, M.D.				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-25-68		Arbutus Me. Pk.		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 27 1968		Robert E. Fairburn		Arlington S. Phillips		1727 N. Monroe St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6633	
<div style="display: flex; justify-content: space-between;"> 17-A-450 68-6633 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EDWARD T. ALLEN		6/23 - 68 11:40 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			A. STATE Md. B. COUNTY BALTIMORE		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1208 N. BENTALOU STREET		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-23-07	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME CHARLES G. Allen		14. MOTHER'S MAIDEN NAME ELIZA FAUNTLEROY		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Alma Allen 1208 N. Bentalou Street	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made at dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION 18 HOURS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from June 22 19 68 to June 23 19 68, that (X) (we) last saw the deceased alive on June 23 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MARVIN MENDEL M.D.				23B. DATE SIGNED June 23	
23C. PHYSICIAN'S NAME (Type) MARVIN MENDEL M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-68		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968			
25B. NAME OF REGISTRAR Arlington S. Phillips		25C. FUNERAL DIRECTOR 1727 N. Monroe St.			

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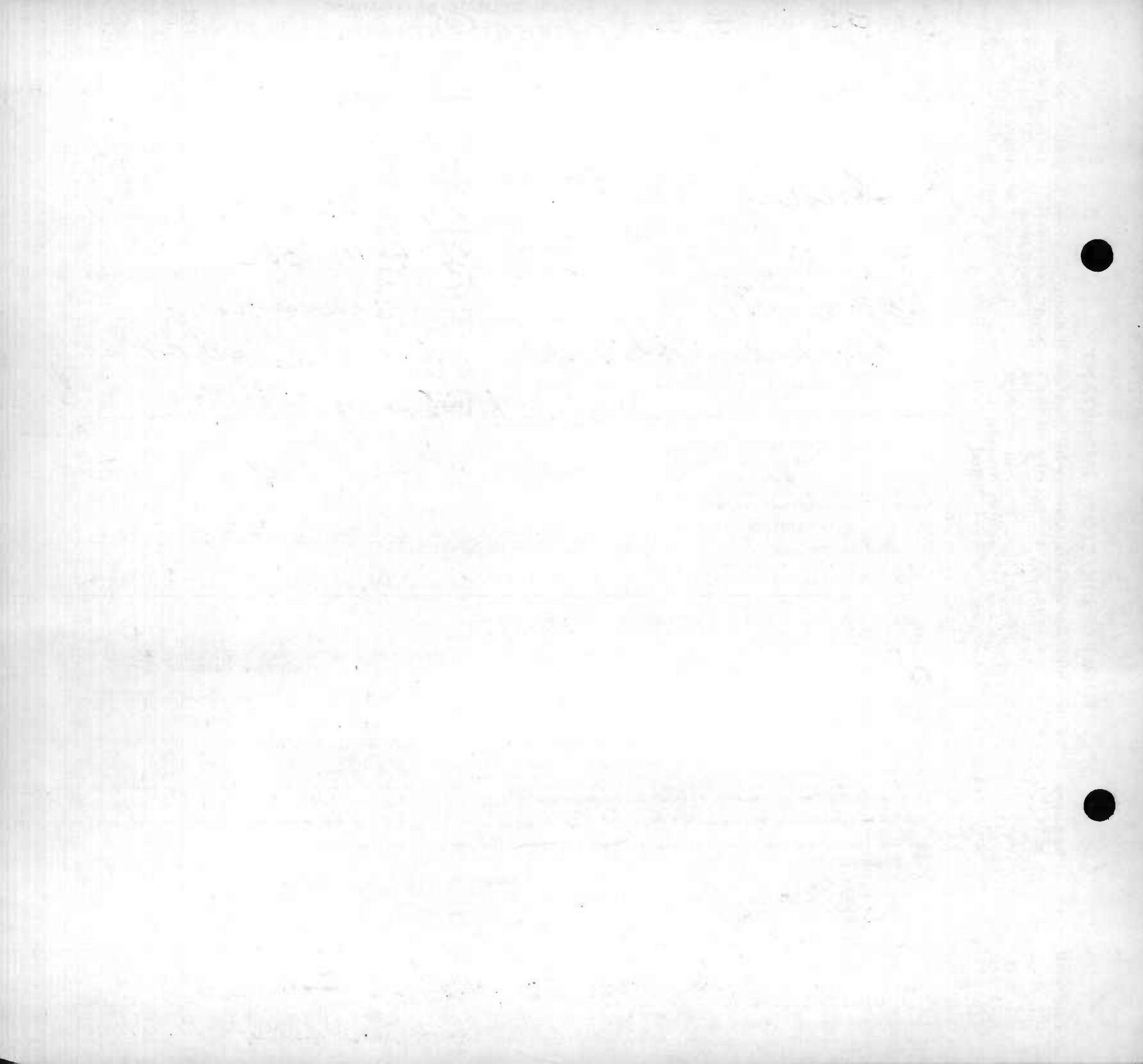
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-328 68-6634		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6634	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Roberta Mitchell</u>		2. DATE AND HOUR OF DEATH <u>6/20/68</u> <u>11:05 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>11722 N. Guilford St.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-29-1914</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>	
13. FATHER'S NAME <u>Moses Johnson</u>		14. MOTHER'S MARRIED NAME <u>Burley Adams</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-18-7037</u>		17. INFORMANT <u>George Mitchell</u>	
18. <u>390.01725019</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aneurysm</u>		<u>months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>metabolic disorders & Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>year</u>	
(C) <u>chronic pyelonephritis</u>				<u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>600.0 II</u>		<u>diabetes</u>		<u>years</u>	
19A. DATE OF OPERATION <u>0 NA</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>6/14</u> 19 <u>68</u> to <u>6/20</u> 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>6/20</u> 19 <u>68</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Joel Barry Alperstein</u>				23B. DATE SIGNED <u>6/20/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOEL BARRY ALPERSTEIN MD.</u>		23D. ADDRESS <u>5101 N. 105th Bldg. MD.</u>			
24A. BURIAL CREATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-24-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carter-Merrick</u>	
24D. LOCATION <u>MD.</u>		24E. NAME OF REGISTRAR <u>Wilmington Phillips</u>			
25A. DATE REC'D. BY HEALTH DEPT. <u>JUN 27 1968</u>		25B. NAME OF REGISTRAR <u>Wilmington Phillips</u>		25C. FUNERAL DIRECTOR <u>1727 N. Mount St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6635
BIRTH NO. 1. NAME OF DECEASED (Type or Print) DAVIS, Annie		2. DATE AND HOUR OF DEATH 6/22/68 4 00 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 724 E. COLD SPRING LANE		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11- -89	9. AGE (In years last birthday) 77
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY 		
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? 		
13. FATHER'S NAME JESSE		14. MOTHER'S MAIDEN NAME SENNIE RANDOLPH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 164-03-2184		
17. INFORMANT Jesse Davis		ADDRESS 		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Lactic acidosis DUE TO, OR AS A CONSEQUENCE OF: (B) Hypotension 2° hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) Probable carcinoma, lung hepatic metastases hypoparathyroidism		
19. DATE OF OPERATION 163X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from 6/22 19 68 to 6/22 19 68 , that (I) last saw the deceased alive on 6/22 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.				
23A. SIGNATURE Elizabeth H. Jansson M.D.		23B. DATE SIGNED 6/22/68		
23C. PHYSICIAN'S NAME (Type) ELIZABETH H. JANSSON M.D.		23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-23-68		
24C. NAME OF CEMETERY or CREMATORY Mt. Lawn		24D. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania		
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Arlington S. Phillips		
25C. FUNERAL DIRECTOR 1727 N. Monroe Street		ADDRESS 		

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T-524 68-6636 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6636

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PERIN <i>De la Nor</i> TINSLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> June 23, 1968 7:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1968 7:30 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-21-1933 34		10. AGE (In years) 34	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? Commie F. Neale	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 452-66-9128	
18. INFORMANT Eleanor Tensley		ADDRESS 845 E. Cold Spring Lane	
19. <i>4/12/21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6/24/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-68	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Arlington S. Phillips		1727 N. Monroe St.	

VS 151-REV. 1/1/68

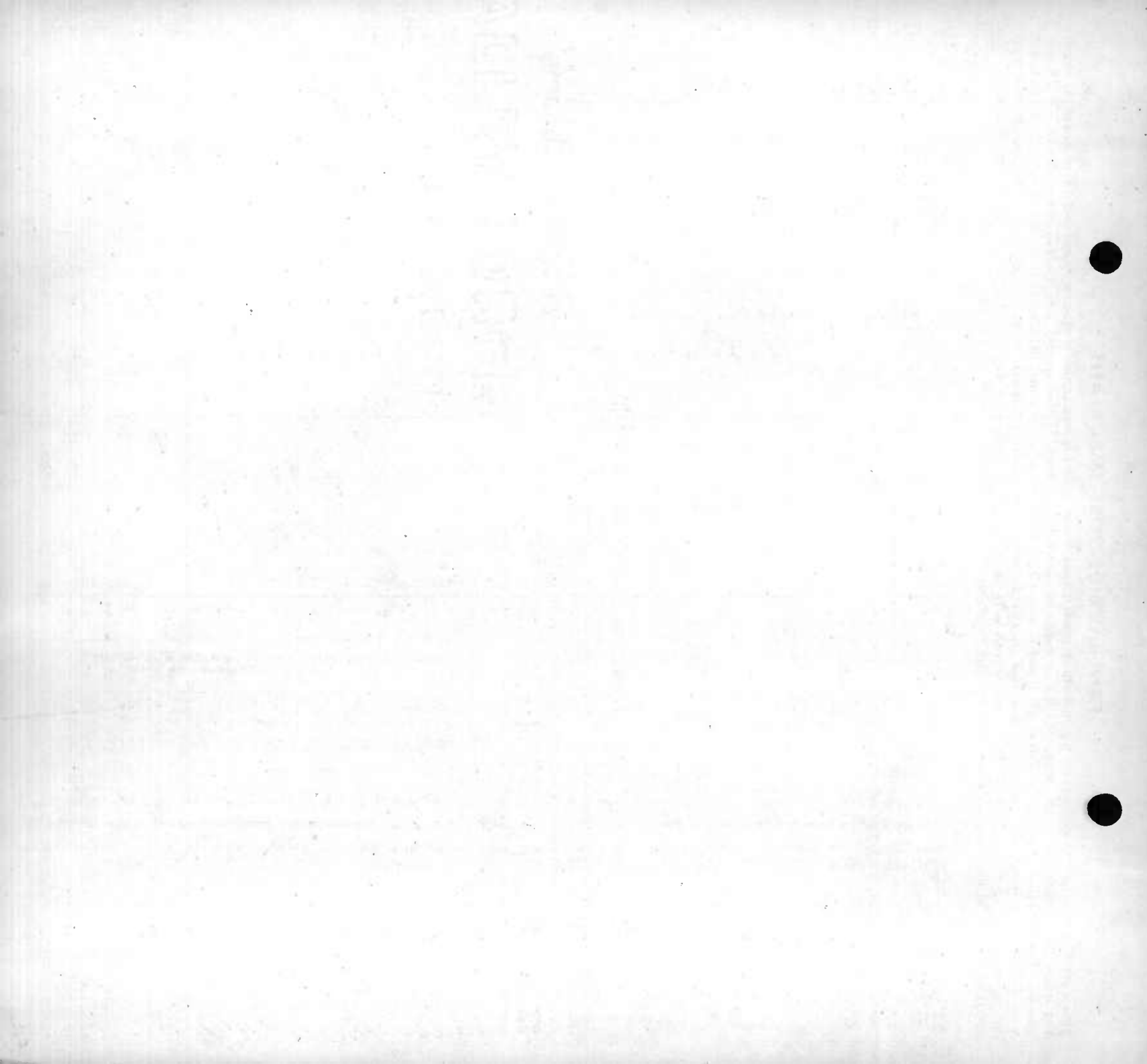
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD <i>Lamar</i> CLAYTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 23, 1968 4:10 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 23, 1968 4:10 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-9-1940		10. AGE (In years lost birthday) 28	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2922 Southland Avenue
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward Clayton	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY Post office		15. MOTHER'S MAIDEN NAME Bessie Gross	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-36-6699		18. INFORMANT Bettye Clayton 2400 Linden Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E968X I Multiple Injuries complicated by Bronchopneumonia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION E983X II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Building 3rd fl.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unk.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 10, 1968 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject jumped from 3rd fl. window after being chased with razor	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 23, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-27-68	24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968	25B. NAME OF REGISTRAR R. E. Johnson	25C. FUNERAL DIRECTOR Delinger & Phillips		ADDRESS 1727 N. Meade	

Paul Walker

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-552 68-6638		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6638	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Simmons, LOUIE</i>		2. DATE AND HOUR OF DEATH <i>6/24/68 6:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2503 ELSENDIRE AVE</i>	
5. SEX <i>7</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/16/98</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220-09-6430</i>		17. INFORMANT <i>Bolton Hill Nursing Home</i> ADDRESS <i>Same</i>	
18. <i>436.7 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>coronary vas. ather (right)</i> (B) <i>arteriosclerosis generalized</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>arteriosclerosis patchy</i> <i>chronic brain syndrome</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6/20/68</i> <i>years</i> <i>years</i> <i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9/20 1967</i> to <i>6/24 1968</i> , that (I) (we) last saw the deceased alive on <i>6/24 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Al Martin</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/25/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MAUCH MD</i>		23D. ADDRESS <i>2 E. READ ST BALTIMORE 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-26-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 27 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Adelbert S. Kelly</i>			
25D. ADDRESS <i>1227 N. Venable</i>					



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T-512 68- 6639 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68- 6639

BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUFUS THOMPSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968 9:50 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION 626 W. Franklin Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1968 9:50 A. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug 6, 1915		10. AGE (in years lost birthday) 52	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 626 W. Franklin Street
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Thompson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Annie Stewart	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Mary E. Casey 626 W. Franklin Street	
19. 34571 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Epilepsy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Edward F. Wilson, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 22, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-24-68		24C. NAME of CEMETERY or CREMATORY Frost Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Lynchburg Virginia		25A. DATE REC'D BY HEALTH DEPT. JUN 27 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe Street		25D. ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6640	
<div style="font-size: 2em; font-weight: bold;">K-140</div> <div style="font-size: 1.5em; font-weight: bold;">68- 6640</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<div style="font-size: 1.5em;">CATHERINE RUPPEL (RUPPLE)</div>		<div style="font-size: 1.5em;">6-26-68</div> <div style="float: right; font-size: 1.5em;">11:45 P.M.</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em;">LITTLE SISTERS OF THE POOR</div> <div style="font-size: 1.5em;">1200 VALLEY STREET</div> <div style="font-size: 1.5em;">BALTIMORE, MARYLAND 21202</div>		A. STATE <div style="font-size: 1.5em;">MARYLAND</div>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		<div style="font-size: 1.5em;">BALTIMORE</div>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		<div style="font-size: 1.5em;">1200 VALLEY STREET</div>			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years lost birthday)
<div style="font-size: 1.5em;">F</div>	<div style="font-size: 1.5em;">W</div>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<div style="font-size: 1.5em;">11-14-1900</div>	<div style="font-size: 1.5em;">67</div>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<div style="font-size: 1.5em;">LAUNDRY WORKER</div>		<div style="font-size: 1.5em;">LAUNDRY</div>		<div style="font-size: 1.5em;">BALTIMORE, MARYLAND</div>	<div style="font-size: 1.5em;">U.S.A.</div>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<div style="font-size: 1.5em;">FREDERICK J. RUPPEL</div>			<div style="font-size: 1.5em;">LOUISE ? (UNKNOWN)</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
<div style="font-size: 1.5em;">No</div>		<div style="font-size: 1.5em;">215-07-1746A</div>		<div style="font-size: 1.5em;">Little Sisters of the Poor</div>	
				<div style="font-size: 1.5em;">1200 Valley St. Baltimore Md.</div>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		<div style="font-size: 1.5em;">C.V.A.</div>			
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		<div style="font-size: 1.5em;">Severe arteriosclerosis</div>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<div style="font-size: 1.5em;">0</div>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.5em;">1967</div> to <div style="font-size: 1.5em;">June 26 1968</div> , that (I) (we) last saw the deceased alive on <div style="font-size: 1.5em;">June 26 1968</div> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<div style="font-size: 1.5em;">Stanley Ankudas</div>				<div style="font-size: 1.5em;">6-27-68</div>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<div style="font-size: 1.5em;">STANLEY ANKUDAS, M.D.</div>				<div style="font-size: 1.5em;">1101 MAIDEN CHOKE LANE BALT., MD.</div>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<div style="font-size: 1.5em;">Burial</div>	<div style="font-size: 1.5em;">6/29/68</div>	<div style="font-size: 1.5em;">Holy Redeemer</div>		<div style="font-size: 1.5em;">Baltimore</div>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<div style="font-size: 1.5em;">JUN 28 1968</div>		<div style="font-size: 1.5em;">Robert E. Fairbank</div>		<div style="font-size: 1.5em;">Philip Herwig</div>	
				<div style="font-size: 1.5em;">2024 Oakmont</div>	

James of the Holy Roman Empire
Philip Henry of the

D-120

68- 6641

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6641

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN L. DAVIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 26 68 9:50 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5911 Grace Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1968 9:50 a. M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7/5/81		10. AGE (In years lost birthday) 86	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motor Man		14B. KIND OF BUSINESS OR INDUSTRY Coal Mines	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 190-05-4589	
15. MOTHER'S MAIDEN NAME Mollie Magrew		18. INFORMANT Son - Ward Davis	
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/26/68	
24C. NAME OF CEMETERY or CREMATORY Johnstown, Penna.		24D. LOCATION (City, town, or county) (State) Johnstown, Penna.	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Jankowski	
25C. FUNERAL DIRECTOR J. Walter Conklin		25D. ADDRESS 5444 Belair Rd., Balto., Md.	

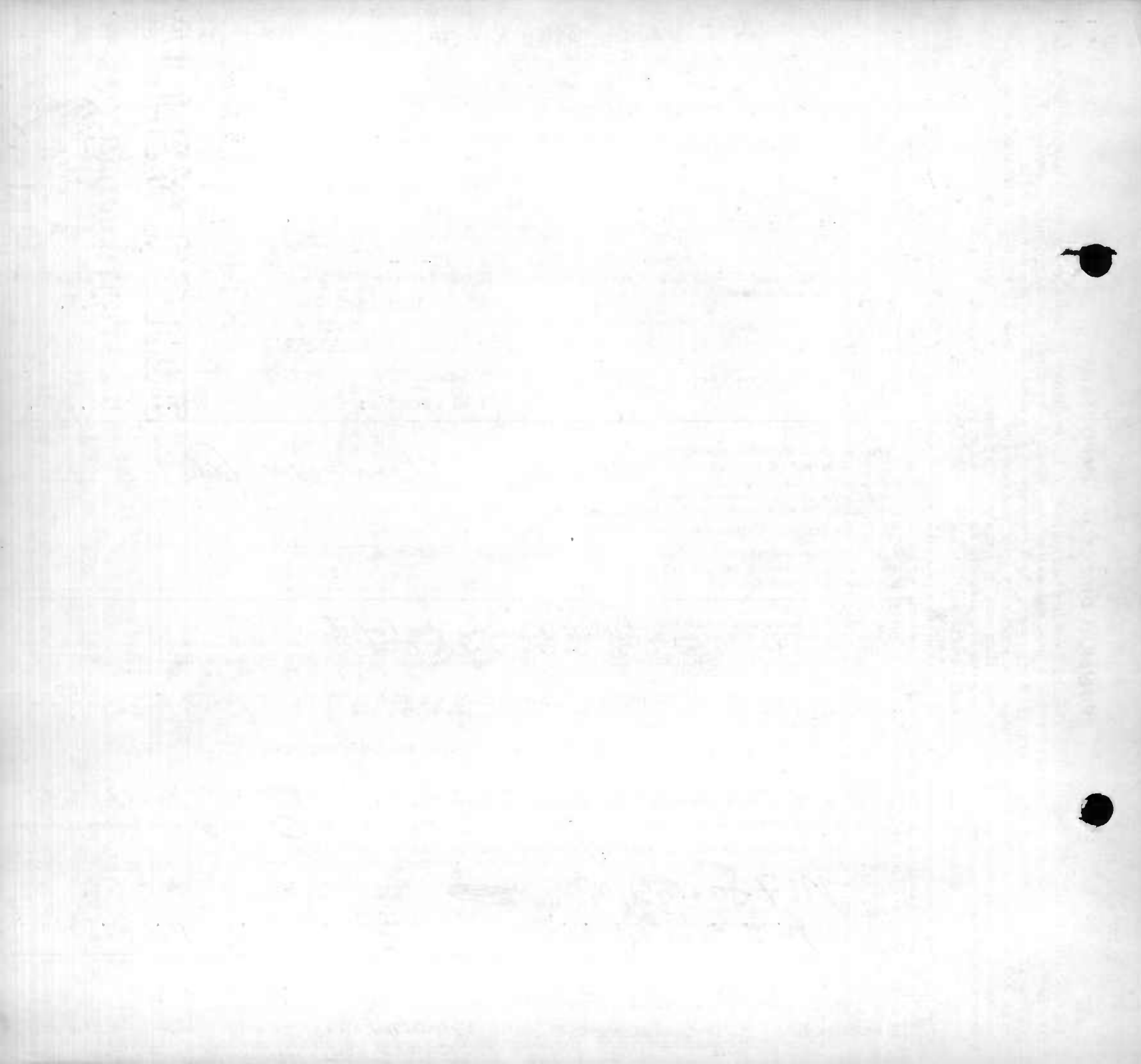
VALLEY FORT

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6642	
1. NAME OF DECEASED (Type or Print) <i>Hazel Marie Dailey</i>		2. DATE AND HOUR OF DEATH <i>6.25.68</i> 1 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>Baltimore</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <i>500 Potomac Ave. #21237</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-14-15</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>E. Bruce Brannon</i>		14. MOTHER'S MAIDEN NAME XXXXXXXXXX <i>Octava Ziler</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>BCH Records: 4940 Eastern Ave., Balto., Md.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Chronic renal failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Hypertension</i> <i>Recurrent urinary tract infections</i> <i>Diabetes mellitus</i>			
19A. DATE OF OPERATION <i>5-9-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>II</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>1/24</i> 19 <i>68</i> to <i>June 25</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>June 25</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>M. F. Saiontz, M.D.</i>		23B. DATE SIGNED <i>6.25.68</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. M. F. SAIONTZ, M.D.</i> <i>M.F. Saiontz, M.D.</i>	
23D. ADDRESS <i>4940 Eastern Ave., Balto., Md.</i> <i>Balto. City Hospitals</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/30/68</i>	
24C. NAME of CEMETERY or CREMATORY <i>Chestnut Grove,</i>		24D. LOCATION (City, town, or county) (State) <i>Frederick Co. Va.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fasham</i>		25C. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME</i>		ADDRESS <i>4210 BELAIR</i> <i>FOR OMPJ HOME WINCHESTER VA</i>	



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D-500 68-6643 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-6643

BIRTH NO. _____ REG. NO. _____

1. NAME OF DECEASED (Type or Print) Bessie Patsy PATSY BESSIE DUNN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 27, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 726 E. Preston Street 9/30/68		3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1968 4:10 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6-22-13		10. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Milas Burris		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Lizzy Worthy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 217-05-4019		18. INFORMANT Thomas Jesse Dunn 726 E. Preston St. 21202	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. DATE SIGNED June 27, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A. A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Farley, Jr.	
25C. FUNERAL DIRECTOR 1735 Harford Avenue 21213		Marshall W. Jones, Jr.	

VS 151-REV. 1/1/68

9/30/68 - Letter from Office of the Medical Examiner, 700 Fleet

Street stating name should be Bessie Patsy Dunn.

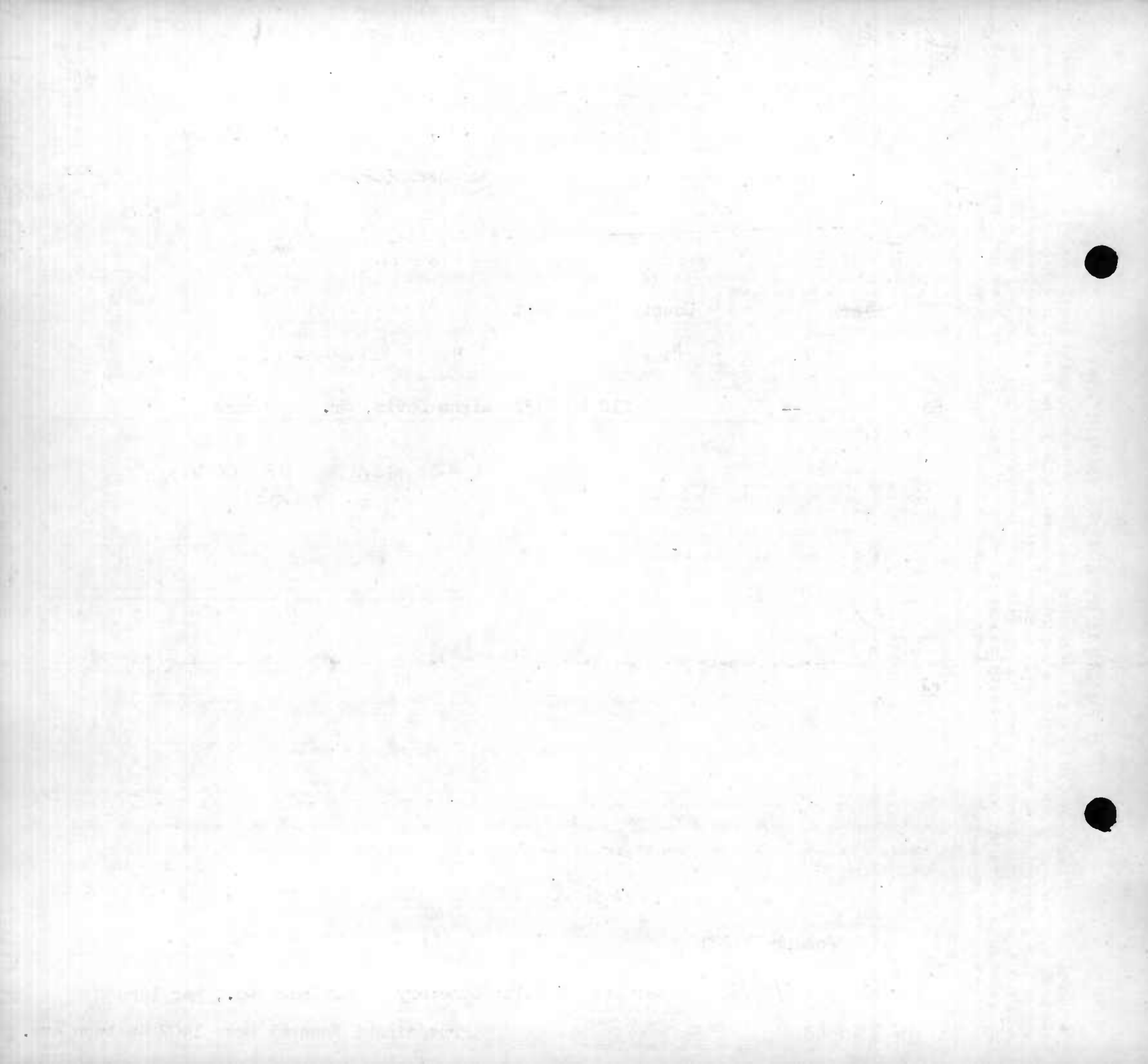
Signed: Charles S. Springate, M.D., Assistant
Medical Examiner.

7-1-69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6644
D-120		68- 6644 CERTIFICATE OF DEATH		
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) LILLIAN E. DAVIS		2. DATE AND HOUR OF DEATH 6-25-68 11 30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF Md HOSPITAL BALT. Md		C. CITY OR TOWN Essex (21) 22		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER 1812 Kitty Hawk Rd. 53-00		
5. SEX F	6. RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-16	9. AGE (In years lost birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY County Government		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA.				
13. FATHER'S NAME John Ester		14. MOTHER'S MAIDEN NAME Ella Clevenger.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 212 40 6151		17. INFORMANT Alpha Davis, Sr.
		ADDRESS Same		
18. 180X I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF cervix metastatic.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
121X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from 6-18- 19 68 to 6-25 19 68 , that (H) (we) lost saw the deceased alive on 6-25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Joseph Insoft				23B. DATE SIGNED 6-25-68
23C. PHYSICIAN'S NAME (Type) Joseph Insoft		23D. ADDRESS Univ. Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery
		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Tankey		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 10-160		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6645	
1. NAME OF DECEASED (Type or Print) JOSE NAVARRO			2. DATE AND HOUR OF DEATH 6/27/68 3:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGIN ISLANDS B. COUNTY C. CITY OR TOWN CHRISTIONSTED, ST CROIX D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER ESTATE PROFIT PLOT 13 7-5		
5. SEX MALE	6. RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/58	9. AGE (In years last birthday) 9	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) ST. Croix, V.I.		12. CITIZEN OF WHAT COUNTRY? V.I.
13. FATHER'S NAME NAZARRIO NAVARRO			14. MOTHER'S MAIDEN NAME EDUALDA GOMEZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Johns Hopkins Hosp - Records		ADDRESS
18. 394.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 410X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 3 6/26 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MITRAL STENOSIS INSUFFICIENCY 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) PLUS INSULT RE MITRAL VALVE REPLACEMENT - OPEN HEART SURGERY 6/26 (B) DUE TO, OR AS A CONSEQUENCE OF: (C) RHEUMATIC HEART DISEASE 2 yrs.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			(If in Baltimore City, give exact location)		
22. I certify that (I) (this hospital) attended the deceased from 6/9 19 68 to 6/27 19 68, that (I) (we) last saw the deceased alive on 6/27/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE			23B. DATE SIGNED 6/27/68		23C. PHYSICIAN'S NAME (Type) STEPHEN H. BRENNERT DEGREE
23D. ADDRESS 550 N. Broadway			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7/3/68			24C. NAME OF CEMETERY OR CREMATORY Christionsted Cem. ST. Croix V.I.		
24D. LOCATION (City, town, or county) (State)			25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		
25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Leonard J. Ruck, inc. 5305 Harford Rd. Balto. Md.		

1/12/53

M

Metaphorical Failure

61 PAGES INSET TO METAPHORICAL
REPLACEMENT - OPEN MIND EXERCISE
KNOWLEDGE HIGHER DISTANCE

Metaphorical Failure

c/50

c/50

c/50

c/50

12/1/53

250 N. 15th Street

STATION 11 STREET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6646	
F-653 68-6646		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs. Mary Catherine Thornton		June 27, 1968 1:43 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 91 Jenkins Memorial Hospital 1000 Caton Avenue Baltimore, Md. 21229		A. STATE Md.		B. COUNTY City 27-10	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 601 E. 43rd St.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1894	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel M. Fitzgerald		14. MOTHER'S MAIDEN NAME Margaret O'Connell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown 20		16. SOCIAL SECURITY NO. 219-20-8394		17. INFORMANT Jenkins Memorial Hospital 1000 Caton Ave.	
18. 582.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Septicemia of the colon</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis of the heart</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>C.H.F. see to above</i> (C) <i>"</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years General "	
MEDICAL CERTIFICATION 372.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 66 to 27 June 19 68, that (I) (we) lost saw the deceased alive on June 27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel de J. Rodriguez</i>		23B. DATE SIGNED 6-27-68		23C. PHYSICIAN'S NAME (Type) Manuel de J. Rodriguez, M.D.	
23D. ADDRESS Jenkins Memorial Hospital, Balto, Md. 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-140		68-6647		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 68-6647	
BIRTH NO.					1				
1. NAME OF DECEASED (Type or Print) JAMES A. DUVALL					2. DATE AND HOUR OF DEATH 6/24/68 11:10 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.					C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					E. STREET AND NUMBER 109 FAIR FIELD DRIVE				
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/14/94	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME CHARLES DUVALL				14. MOTHER'S MAIDEN NAME MARGARET RIDOUT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-01-9746		17. INFORMANT Mrs Margaret Duvall ADDRESS Same as deceased			
18. 185-X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of Prostate with metastasis					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				
19. 177X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). X.S.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from June 22 19 68 to June 24 19 68 , that (I) (we) last saw the deceased alive on June 24 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Enrique Cipriani M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6/24/68	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI MD					23D. ADDRESS 3327 Calvert St.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-1968		24C. NAME OF CEMETERY or CREMATORY St. Johns Cemetery			24D. LOCATION (City, town, or county) (State) Howard County Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Talley			25C. FUNERAL DIRECTOR John H. Talley			ADDRESS Calverton - 18PM	

Prof. Dr. J. H. ...

University of ...
Department of ...
...

No.

24

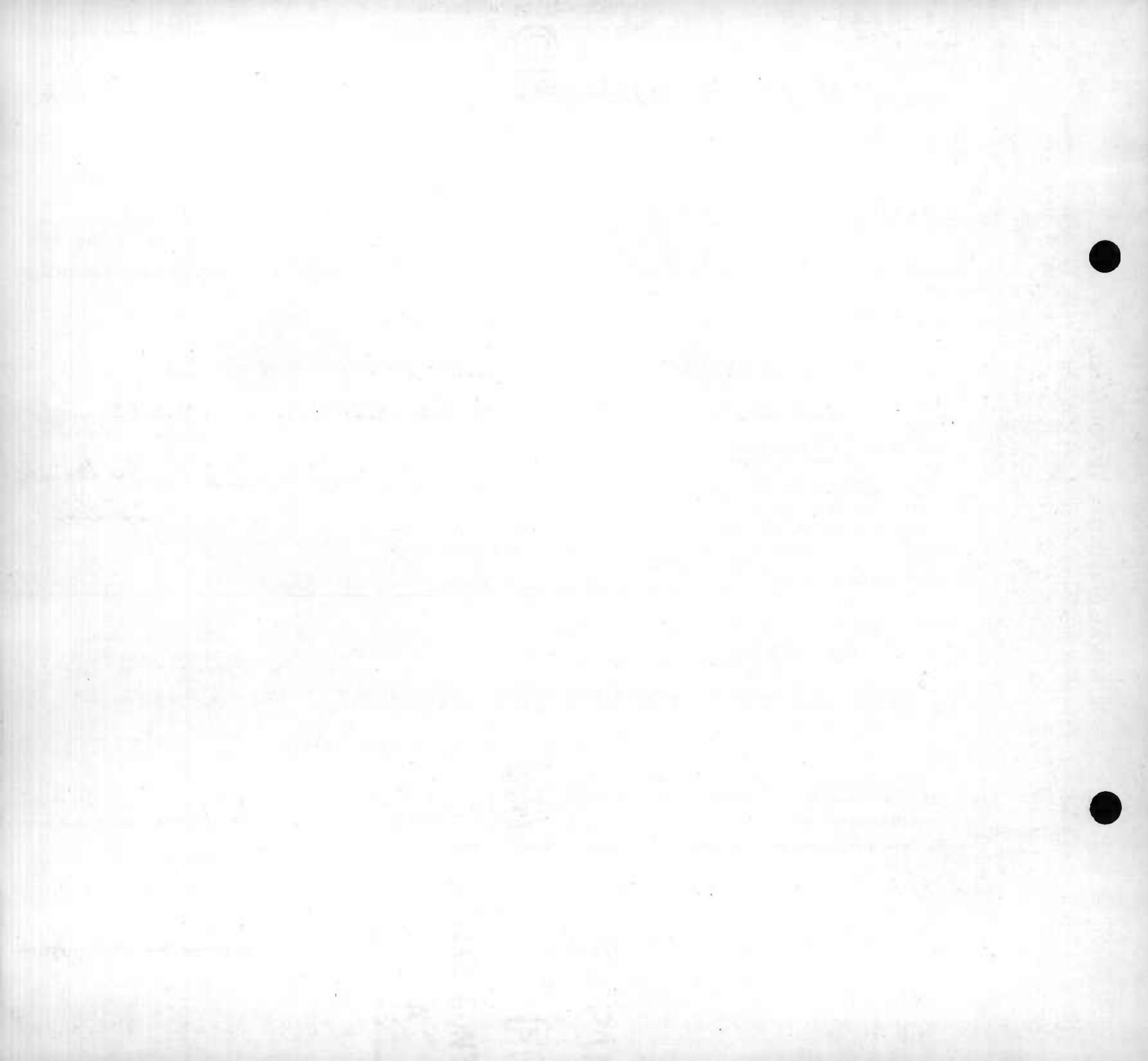
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6648
G-125 68- 6648 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WALTER S. GIBSON		2. DATE AND HOUR OF DEATH 6/25/68 3:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTO. CITY HOSP		C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 302 MARGARET AVE 5300			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/31/99	9. AGE (In years lost birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREFMAN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES GIBSON		14. MOTHER'S MAIDEN NAME KATHRYN DRYER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ANNA GIBSON ABOVE	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 15 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1950 1950 to 6/25 1968 , that (I) (we) lost saw the deceased alive on 6/25 1968 and that in (my) (our) apiman death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. 3 a.m.					
23A. SIGNATURE Morris A. Jacobs M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/25/68	
23C. PHYSICIAN'S NAME (Type) MORRIS A. Jacobs M.D.		23D. ADDRESS 1010 North Point Road Balto 21224 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/28/68		24C. NAME OF CEMETERY or CREMATORY SACRED HEART	
24D. LOCATION BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS J. J. CONNELLY SONS 300 MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6649	
BIRTH NO. K-365		68-6649		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Barbara Koppna			2. DATE AND HOUR OF DEATH June 26, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 913 N. Bradford St.			A. STATE Maryland B. COUNTY 7-03		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 913 N. BRADFORD ST.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1978	9. AGE (In years lost birthday) 89	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215 0747790		17. INFORMANT George F. Koppna 809 N. Port St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral hemorrhage (B) Cerebral arteriosclerosis (C) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs ? ?
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/6 1967 to 6/26 1968 that (I) (we) last saw the deceased alive on 6/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Kline MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) LOUIS F. KLINE MD				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Embury Bldg. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Philip S. Gosh 124 Chesaco Ave	

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Handwritten text in the middle section, continuing the notes or list.

Handwritten text in the lower middle section, possibly a paragraph or detailed notes.

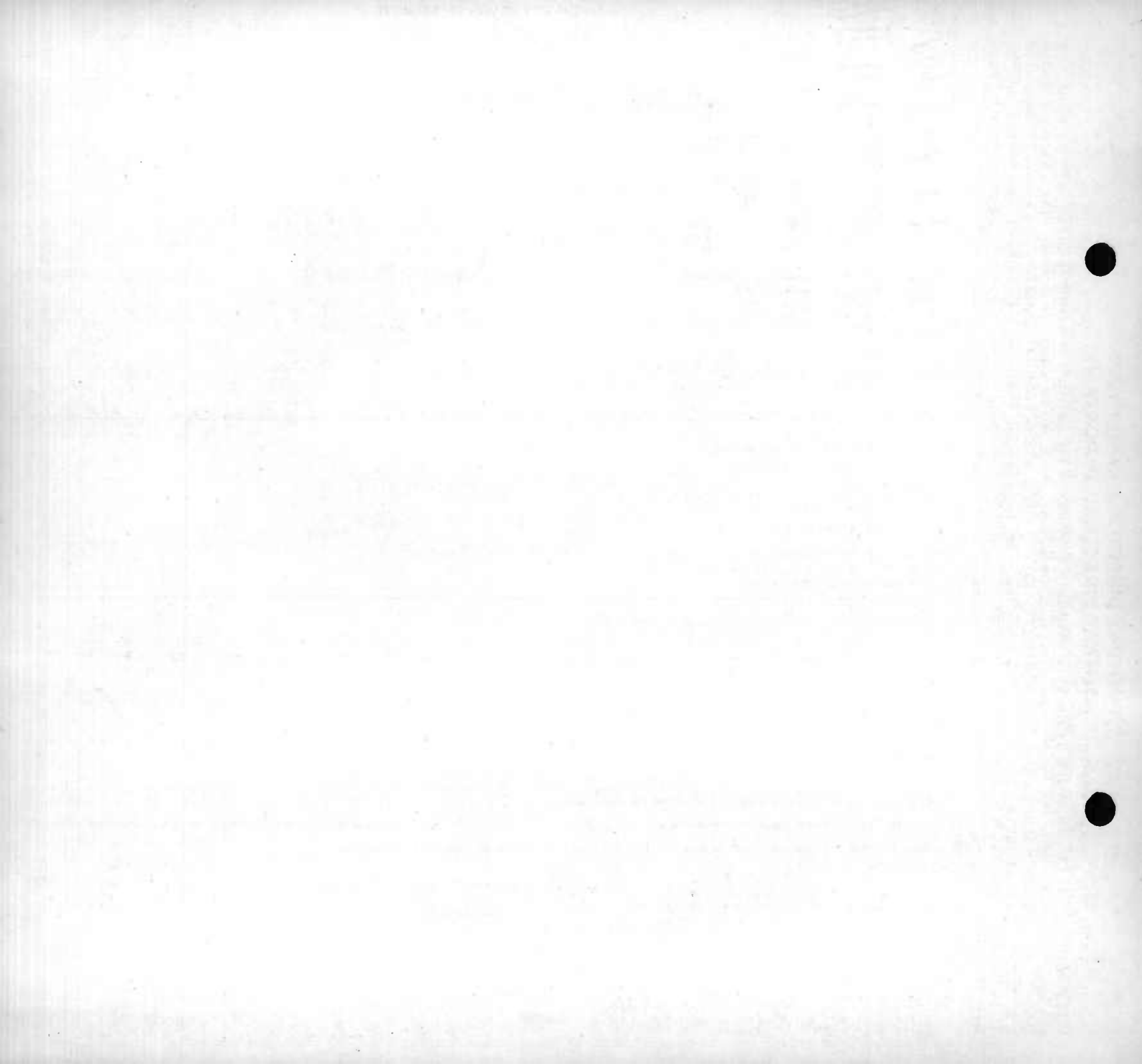
Handwritten text in the lower section, continuing the notes or list.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 68-6650
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>CHARLES KIRBY</u>		2. DATE AND HOUR OF DEATH <u>6/26/1968</u> <u>6⁵⁰</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1703 COLE ST.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1703 COLE ST. BALTO. MD</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/1896</u> 9. AGE (In years last birthday) <u>72</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SANITATION DEPT.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CITY</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOSEPH KIRBY</u>		
14. MOTHER'S MAIDEN NAME <u>DOROTHY ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>		
16. SOCIAL SECURITY NO. <u>212-18-3979</u>		17. INFORMANT <u>MYRTLE SHOOT</u> <u>1106 LEONARD DRIVE GLEN BURNIE, MD.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION <u>4/20/11</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> <u>1968</u> to <u>6/26</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>HARRY DEIBEL M.D.</u>		23B. DATE SIGNED <u>6/29/68</u>		23C. PHYSICIAN'S NAME (Type) <u>HARRY DEIBEL M.D.</u>
23D. ADDRESS <u>1256 HANOVER ST BALTO 21230 Md</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>6/28/1968</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		
24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Harkness</u>		25C. FUNERAL DIRECTOR <u>John J. Cooper & Son, Inc. 901 Hollins St Balto. Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-500		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 6651	
68- 6651		CERTIFICATE OF DEATH		68- 6651	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Wain Audrey Lee</i>		2. DATE AND HOUR OF DEATH <i>6-26 '68 5:00 A.M.</i>	
M.E. CASE NO.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>AACO</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hosp.</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 25 62-00</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>		D. STREET ADDRESS (If rural, give location) <i>618 Sunset Strip</i>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>7/22/30</i>		9. AGE (In years lost birthday) <i>37</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>Vaughn Hopkins</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Hopkins</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. George E. Wain 618 Sunset Strip 21225</i>	
18. <i>427.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>heart failure</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>sepsis</i>			
		(C) <i>renal insufficiency</i> <i>congestive heart failure</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>434.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-25 1968</i> to <i>6-26 1968</i> , that (I) (we) last saw the deceased alive on <i>6-26 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nak Joong Im</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Nak Joong Im</i>				23D. ADDRESS <i>Franklin Sq Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/29/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>McCallister H.</i>		25D. ADDRESS <i>237 Patapsco Ave. 21225</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-651		68- 6652		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6652	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) EHRENPREIS SIDNEY			
2. DATE AND HOUR OF DEATH 6-26-68				P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN 21207 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6823 HUNTINGTON DRIVE 5300							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-18	9. AGE (in years lost birthday) 49	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY CLUB MANAGER 602		11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? YES	
13. FATHER'S NAME MAX				14. MOTHER'S MAIDEN NAME MINNIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 216-03-4552		17. INFORMANT ANNETTE (NEE) ZACKON		ADDRESS = SAME =	
18. 1579 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Edema				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cholelithiasis & cholecystitis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pancreatic carcinoma & metastatic				(B) DUE TO, OR AS A CONSEQUENCE OF: Metastatic			
(C) _____							
1579 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6-19-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fair		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 10:00 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jun 1 19 68 to Jun 26 19 68 , that (I) (we) last saw the deceased alive on Jun 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Seymour Kowalsky				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/26/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-68		24C. NAME of CEMETERY or CREMATORY BETH TFIOR		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR R. L. E. Faltus		25C. FUNERAL DIRECTOR SYLVAN B. LEWIS & SON		ADDRESS GARRISON MD.	

10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6653
3-520 68-6653		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Jones Maude (Maud)</i>		2. DATE AND HOUR OF DEATH <i>6-23-68 9:30 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bolton Hill Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY C. CITY OR TOWN <i>Maryland</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>400 John St.</i>		
5. SEX <i>Fe</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/25/80</i>	9. AGE (In years lost birthday) <i>87</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Admission Record</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolus</i> <i>ASCVD</i> (B) Right Intertoracic Fracture DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> <i>years</i> <i>3 months</i>
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home Hospital</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>not certain Baltimore City Hosp</i>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>3-21-68</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Fell while trying to get out of Bed.</i>
22. I certify that (I) (this hospital) attended the deceased from <i>6/12</i> 19 <i>68</i> to <i>6/23</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/20</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Stephen Toms, M.D.</i>		23B. DATE SIGNED <i>6/24/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Stephen Toms, M.D.</i>
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-27-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart</i>
24D. LOCATION (City, town, or county) (State) <i>13 Balto. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>
25C. FUNERAL DIRECTOR <i>Thelma A. Hoffmann</i>		25D. ADDRESS <i>3218 Hudson St</i>		

12-11-17

Chimney

ASCO

Fracture of right hip

Left side of hip

right

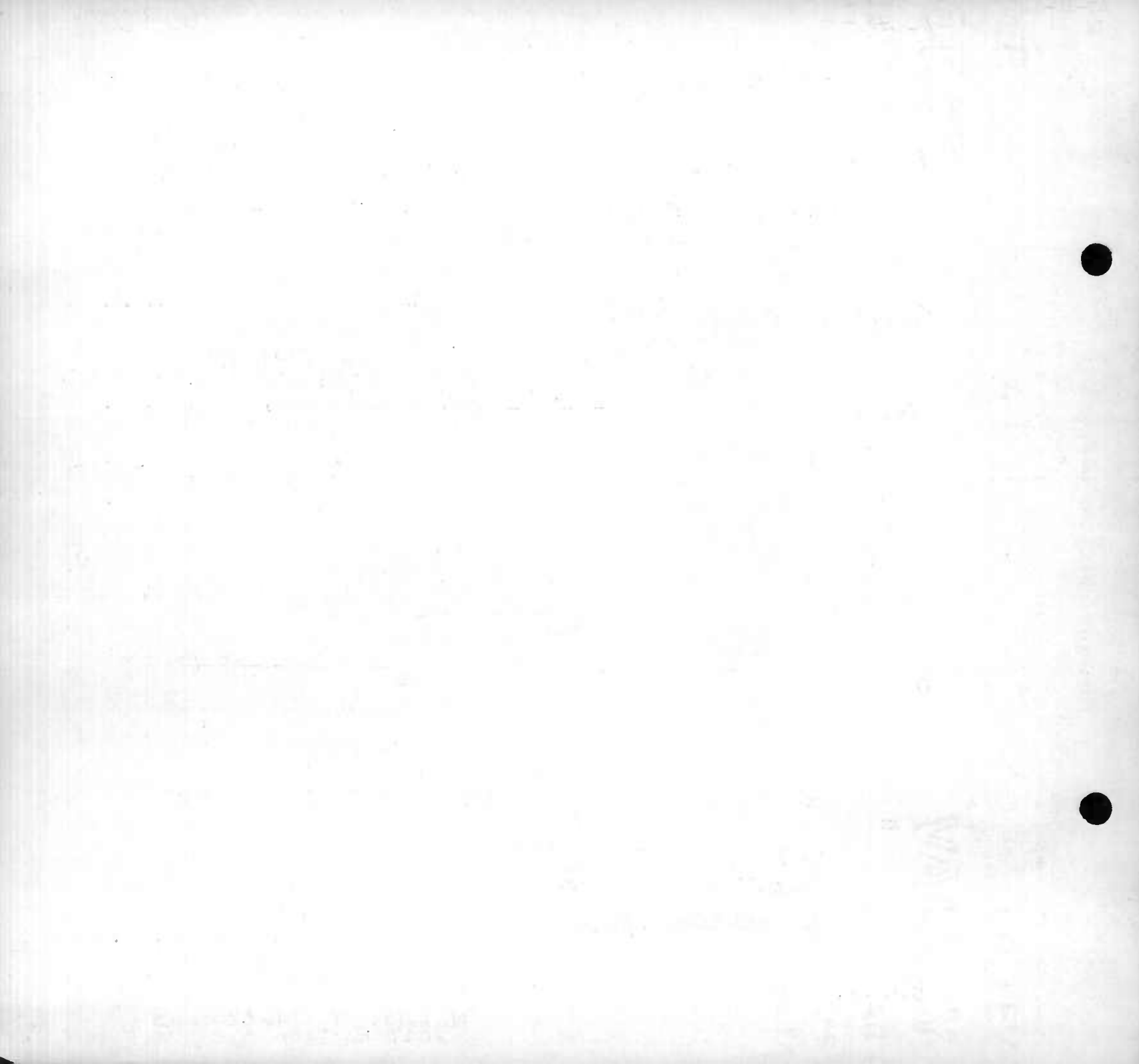
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12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

47-10-34 IW		L-552		68- 6654		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6654	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SAVASTOS LEMONIS				2. DATE AND HOUR OF DEATH JUNE 25, 1968 6¹⁰ A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER 419 S. EAST AVENUE - 21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/27/89		9. AGE (In years last birthday) 78		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. Tailor Shop				10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES LEMONIS				14. MOTHER'S MAIDEN NAME Maroula Kantana					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-34-9563-A		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224			
MEDICAL CERTIFICATION		18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH >15 years	
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:							
		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 430.0 II Pulmonary edema COPD BPH							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that ID (this hospital) attended the deceased from 6/22 19 68 to 6/25 19 68 , that ID (we) last saw the deceased alive on 6/25 19 68 and that in ID (our) opinion death occurred on the date and hour and from the causes stated above ID (We) (did) (not) view the body after death.									
23A. SIGNATURE Joel Thurm M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/25/68	
23C. PHYSICIAN'S NAME (Type) JOEL THURM M.D.						23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Rebecca T. Matthews		25C. FUNERAL DIRECTOR Nicholas T. Matthews		ADDRESS 3020 Eastern Ave., Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6655	
0-164		68-6655		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Hena H. Oberlander		6-24-1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Church Home Hospital		Md. Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Church Home Hospital		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female	Cau.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
				9-25-1890	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Housewife	Housewife	Baltimore, Maryland		77	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Henry Classen		unknown Mertins		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.		219-16-3778		21206	
				William F. Oberlander 114 Raspe Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		II		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
—		—		—	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
—		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		—	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 and that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
V. Sadarananda M.D.		6/26/68		V. SADARANANDA	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)			
680 1 Belair Rd Balto 6 Md		Burial			
24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
6-27-1968		Parkwood Cemetery		Baltimore Co. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 28 1968		Robert E. Falek		21236	
		Lassahn Funeral Home 7401 Belair Road			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6656
H-560 68-6656 BIRTH NO. 1. NAME OF DECEASED (Type or Print) KATHERINE HENRY		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 6/25/68 12:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 6. CITY OR TOWN WHITE MARSH 7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 8. STREET AND NUMBER 676A BANGERT ST. 53-00		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1893	9. AGE (In years lost birthday) 74 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) PROSPECT, MD.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM LEE		
14. MOTHER'S MAIDEN NAME MARY E. BROWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 186-26-7009		17. INFORMANT MRS. RALPH KRICK, BALTIMORE, MD. 21237		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0				
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE Acute myocardial infarction 5 days DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6/24 1968 to 6/25 1968. that (I) (we) last saw the deceased alive on 6/25 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Louis E. Grenzer			23B. DATE SIGNED 6/25/68	
23C. PHYSICIAN'S NAME (Type) LOUIS E. GRENZER			23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-27-68	24C. NAME OF CEMETERY or CREMATORY TABERNACLE	24D. LOCATION (City, town, or county) (State) WHITEFORD, HARFORD Co., MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA.

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TO BE APPROVED BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

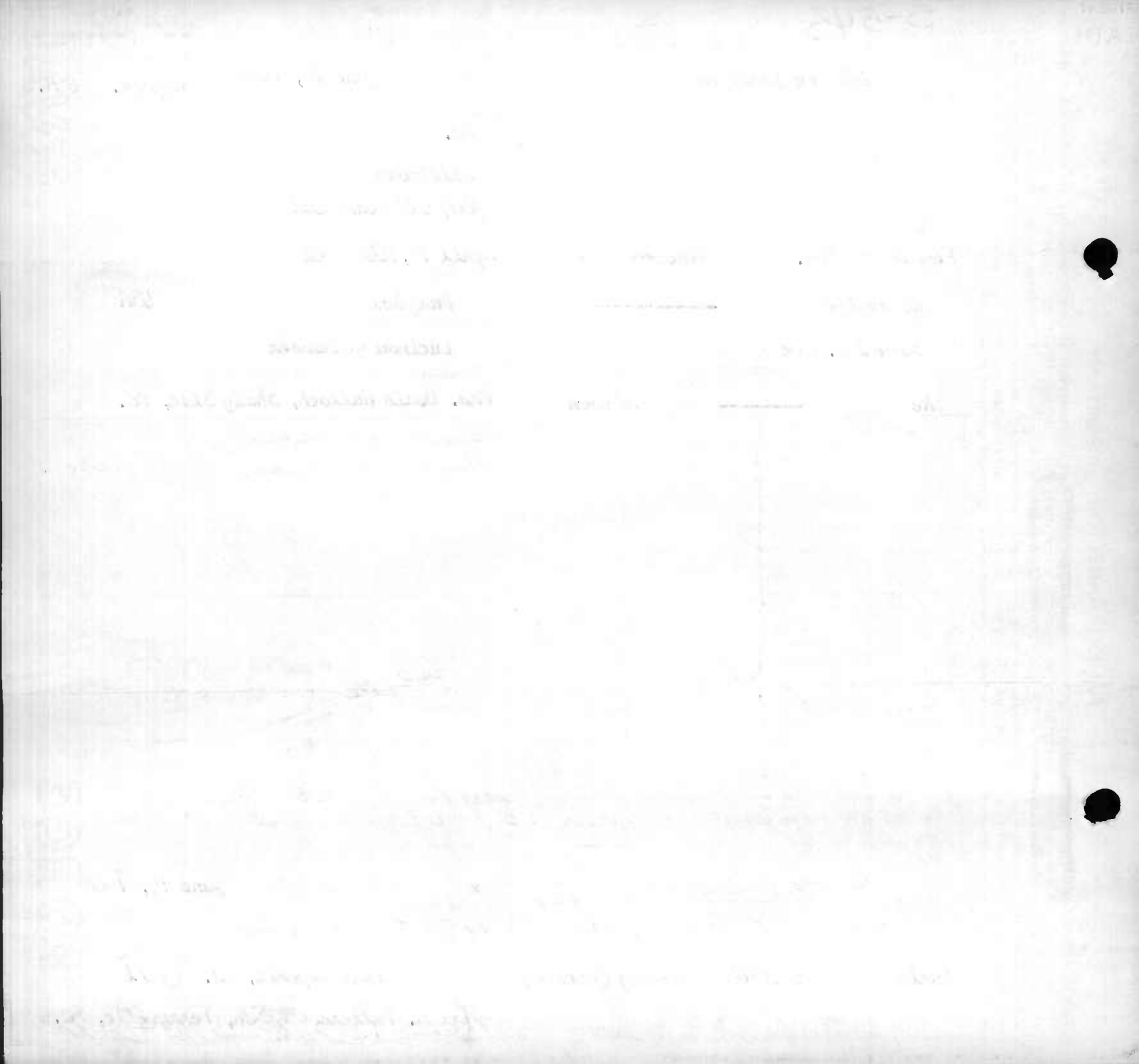
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-563 68-6657				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6657	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FREDERICK CONRAD				2. DATE AND HOUR OF DEATH 6-27-68 6:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5308 Tramm Rd.							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-43	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-- Hardware Business				11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Conrad				14. MOTHER'S MAIDEN NAME Annie M. Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 7-05-8503A		17. INFORMANT Mrs. Ida M. Conrad	
				ADDRESS (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4319 I				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, arising rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE SUBDURAL HEMATOMA DUE TO, OR AS A CONSEQUENCE OF:			
				(B) BRONCHOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A, B, C) 331X II							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-22-68 19 to 6-27-68 19, that (I) (we) last saw the deceased alive on 6-27-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles Macaplan, M.D.				23B. DATE SIGNED 6-27-68		23C. PHYSICIAN'S NAME (Type) CHARLOTTE BARBARA FELICIANO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 68- 6658	
BIRTH NO. S-543		68- 6658		CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Lida Fox Smeltzer			June 18, 1968 approx. 6 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3609 Old York Road			A. STATE Md. B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 3609 Old York Road		
5. SEX Female	6. RACE Cau.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH April 19, 1886	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel S. Fox			14. MOTHER'S MAIDEN NAME Lucinda Gerhauser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Mrs. Doris Hallock, Shady Side, Md.	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic Heart Disease			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 years -
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.0 II					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 10 1963 to June 18 1968 , that (I) (we) last saw the deceased alive on June 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer				23B. DATE SIGNED June 19, 1968	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER				23D. ADDRESS 4808 Harford Rd. Balto 14 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/20/68		24C. NAME OF CEMETERY or CREMATORY Asbury Cemetery	
24D. LOCATION (City, town, or county) (State) Port Deposit, Md. Cecil		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968			
25B. NAME OF REGISTRAR Robert E. Fairman		25C. FUNERAL DIRECTOR ADDRESS Lee A. Patterson & Son, Perryville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 5-200 68- 6659 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 68- 6659	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) ISAAC SACKS		2. DATE AND HOUR OF DEATH June 27, 1968 12:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Friedler's Guest House		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2449 Shirley Avenue	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1888
9. AGE (In years last birthday) 80		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret		10B. KIND OF BUSINESS OR INDUSTRY Tailor	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Rose	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-30-2323	
17. INFORMANT M. Syhan Sacks		ADDRESS 2103 Sulyrow Ave	
18. 4-12-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arterio Sclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4-20-0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4-20-0 II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Parkinsons Disease (B) DUE TO, OR AS A CONSEQUENCE OF: None (C) None APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 1968 to June 27 1968 , that (I) (we) last saw the deceased alive on June 27 1968 and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.			
23A. SIGNATURE Manuel Levin		23B. DATE SIGNED 6/27/68	
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN MD		23D. ADDRESS 6101 PARK HTS AVE BALTO-15 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68	
24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. F...	
25C. FUNERAL DIRECTOR Syhan S. Lewis & Son, Inc		ADDRESS 9610 Reisterstown Rd	

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BIRTH NO.		REG. NO.	
7-260		68- 6660	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ELMER E. FISHER		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Month Day Year Hour	
00 4211 Ivanhoe Ave.		June 26, 1968 2:00 p.m.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Male		A. STATE B. COUNTY	
7. RACE		C. CITY OR TOWN	
Colored		Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		D. INSIDE CITY LIMITS?	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
8-29-88		4211 Ivanhoe AVE	
10. AGE (In years lost birthday)		13. FATHER'S NAME	
79		Wm. Fisher	
11. BIRTHPLACE (State or foreign country)		15. MOTHER'S MAIDEN NAME	
Md.		Hannah	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
no		214306182	
18. INFORMANT		ADDRESS	
John Maynor Jr.		same	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		Malignant Melanoma	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
190.9 II		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
0		No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Edward F. Wilson, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		6-29-68	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Stevensonville Cem.		Stevenville, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JUN 28 1968		Robert E. Fisher	
25C. FUNERAL DIRECTOR		ADDRESS	
Vernon R. Bailey		1348 Calhoun St.	

WALTER H. H. H. H.
WALTER H. H. H. H.
WALTER H. H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68- 6661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6661

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Rosemarie Wilson</i>		2. DATE AND HOUR OF DEATH <i>June 27 1968 10 A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>20-05</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Ben Secours Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>FEMALE</i>		6. RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>		8. DATE OF BIRTH <i>July 16, 1941</i> 9. AGE (In years lost birthday) <i>27</i>	
11. BIRTHPLACE (State of foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Richard H. Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Christine Hetmanski</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Christine Wilson</i> ADDRESS <i>322 S. Harrow St.</i>	
18. <i>486 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6.25</i> 19 <i>68</i> to <i>6.27</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6.26</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John M. Kudirka</i>		23B. DATE SIGNED <i>6.28.68</i>		23C. PHYSICIAN'S NAME (Type) <i>J. KUDIRKA</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6-29-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md.</i>		24E. NAME OF REGISTRAR <i>Robert E. Johnson</i>		24F. FUNERAL DIRECTOR <i>GEO. L. SCHWAB</i>	
25A. DATE REC'D. BY HEALTH DEPT. <i>JUN 28 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>GEO. L. SCHWAB</i>	

206
ALLEY



1

G-65068-6662 BALTIMORE CITY HEALTH DEPARTMENT 68-6662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 68-08948 REG. NO.

1. NAME OF DECEASED (Type or Print) VIOLA GREEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 26 68 8:30 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4212 Springdale Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26 1968 8:30 a.m.	
6. SEX Female		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 28-02	
9. DATE OF BIRTH 5/16/1968		10. AGE (In years last birthday) 5 weeks	
11. BIRTHPLACE (State or foreign country) Baltimore MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		14B. KIND OF BUSINESS OR INDUSTRY none	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. none	
13. FATHER'S NAME Ellsworth Green		15. MOTHER'S MAIDEN NAME Lillian Hill	
18. INFORMANT Lillian Green		ADDRESS 4212 Springdale Ave	
19. 484X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Interstitial pneumonitis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 5-23-X		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED II	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) (Minute) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 26, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burn		24B. DATE 6-29-68	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Margaret P. Byers		ADDRESS 638 N. G. Lane St	

VS 151-REV. 1/1/68

WALLLEY JOHN C.

WALLLEY JOHN C.

WALLLEY JOHN C.

WALLLEY JOHN C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6663
5-100		68- 6663		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Minnie Schaaf		
2. DATE AND HOUR OF DEATH 6/26/68		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD General German Aged Home		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.		5. AGE (In years last birthday) 96		
6. CITY OR TOWN Balto.		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. STREET AND NUMBER 22 S. Athol Ave.		9. DATE OF BIRTH 1/20/1872		
10. SEX F		11. RACE W		12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
13. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		14. SOCIAL SECURITY NO.		
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY		
17. BIRTHPLACE (State or foreign country) Md.		18. CITIZEN OF WHAT COUNTRY? U.S.A.		
19. FATHER'S NAME Louis Fehrmann (deceased)		20. MOTHER'S MAIDEN NAME Frances Vollerdt		
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		22. INFORMANT ADDRESS General German Aged Home, Balto., Md.		
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) 403 X I		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chemia (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Nephrosclerosis (C) Generalized Arteriosclerosis		
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 446 X II		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cardiac failure		
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No)
30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
33. TIME OF INJURY (APPROX.)		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. HOW DID INJURY OCCUR?
36. I certify that (I) (this hospital) attended the deceased from Jan 1943 to 26 June 1968 , that (I) (we) last saw the deceased alive on 26 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
37. SIGNATURE William J. Bryson		38. DATE SIGNED 27 June 68		39. PHYSICIAN'S NAME (Type) William J. Bryson
40. ADDRESS 1605 Edmondson Ave Balto 29		41. NAME OF CEMETERY or CREMATORY Immanuel Lutheran		
42. DATE OF BURIAL CREMATION, REMOVAL (Specify) Burial 6/28/68		43. LOCATION (City, town, or county) (State) Baltimore, Md		
44. DATE REC'D BY HEALTH DEPT. JUN 28 1968		45. NAME OF REGISTRAR Robert E. Fabura		46. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave. 21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6664	
J-100 68- 6664				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) I. Rayner Jubb				6/26/68 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4601 MANORDENE RD BALTIMORE, MD.				A. STATE Maryland B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3/20/ 41 9. AGE (In years last birthday) 27	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10B. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Jubb (deceased)				14. MOTHER'S MAIDEN NAME Rebecca	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. 705-03-4815	
17. INFORMANT Mrs. Leah May Hipkins, 410 Northbend Rd.				ADDRESS 21229	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Corny Ambris (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week	
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-22-67 19 to 6-26-68 19, that (I) (we) last saw the deceased alive on 6-24-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Gimbel				23B. DATE SIGNED 6-27-68	
23C. PHYSICIAN'S NAME (Type) Dr. Harry Gimbel				23D. ADDRESS 4605 Edmondson Ave. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY Western	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave. 21229	

1941 November 25
1941 November 25

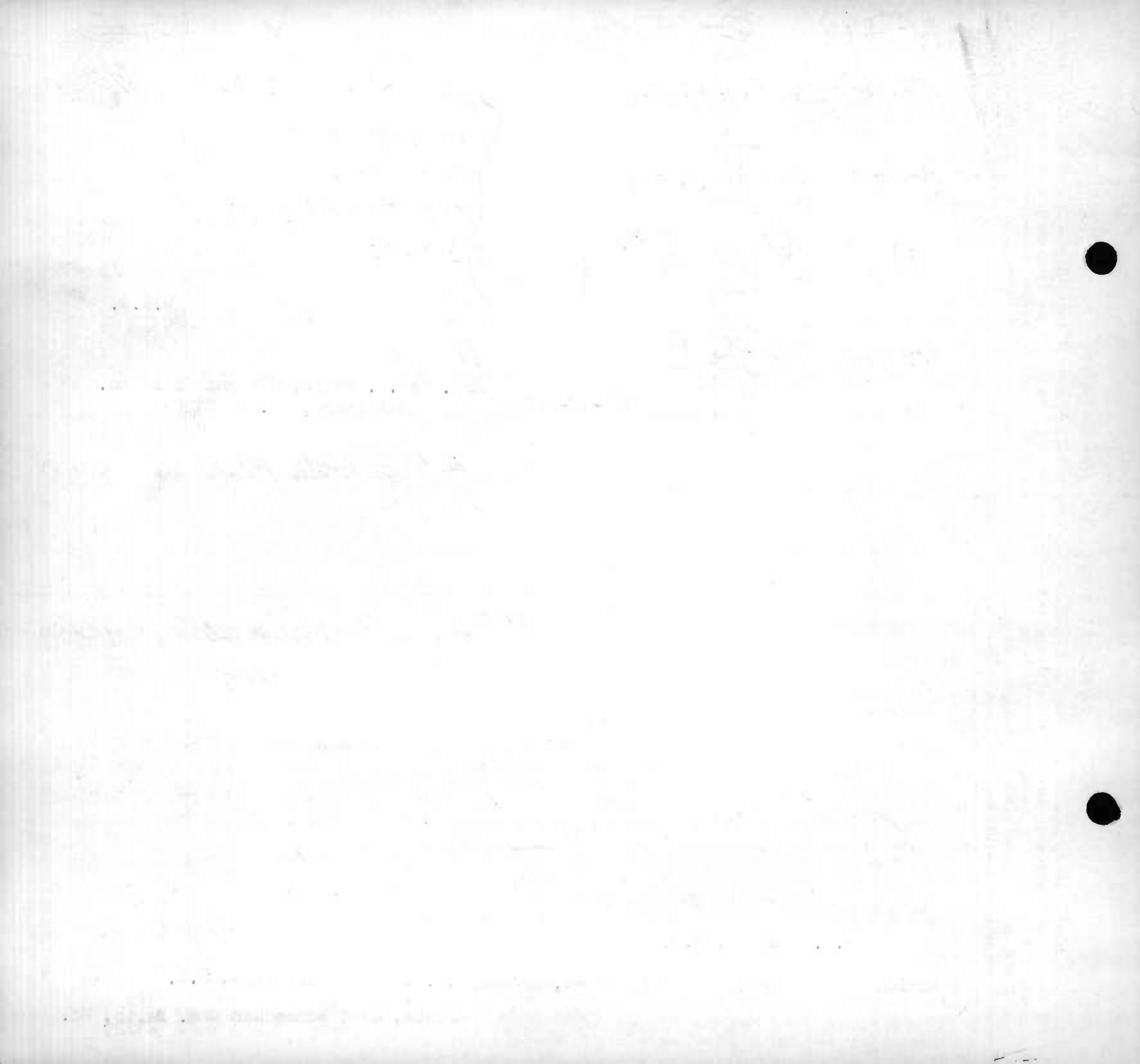
1941 November 25

1941 November 25

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6665
N-240 68-6665		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Mr. George F. Nagle</u>		2. DATE AND HOUR OF DEATH <u>June 27 1968</u> <u>7:30 a. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>927 Masfield Road</u> <u>5300</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/98</u>	9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Nagle</u>		
14. MOTHER'S MAIDEN NAME <u>Nellie</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>117-12-2119A</u>		17. INFORMANT ADDRESS <u>Mrs. Geo. F. Nagle, 927 Masfield Rd. Baltimore, Md. 21207</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>420.0 II Pulmonary Emphysema</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> <u>YEARS</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>6/24/68</u> to <u>6/27/68</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>6/27/68</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>M. J. Hashemi, M.D.</u>		23B. DATE SIGNED <u>6/27/68</u>		23C. PHYSICIAN'S NAME (Type) <u>M. J. Hashemi, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross, Brooklyn, N.Y.</u>
24D. LOCATION (City, town, or county) (State) <u>Brooklyn, N.Y.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 28 1968</u>		
25B. NAME OF REGISTRAR <u>A. J. E. F. F. F.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 4101 Edmondson Ave. Balt. Md. 21229</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6666	
1. NAME OF DECEASED (Type or print) <i>Allie Stackhouse</i>		2. DATE AND HOUR OF DEATH <i>June 26/68 8:50 PM</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>18-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>831 W. Lexington St.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>6-2-24</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>So. Carolina</i>	
13. FATHER'S NAME <i>Williams, Orendine</i>		14. MOTHER'S MAIDEN NAME <i>Bessie Barnes</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Orendine Williams</i> ADDRESS <i>831 W. Lexington St.</i>	
18. <i>1978</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>choleangiolytic ca of the liver.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cirrhosis of liver, Stress ulcers of duodenum.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>15-6-1 II</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 6/68</i> 19 to <i>June 26/68</i> 19 that (I) (we) last saw the deceased alive on <i>June 26</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>AM Ghiladi</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/27/68.</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Arbutus Mem PK. Arbutus Md</i>	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1968</i>			
25A. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> ADDRESS <i>661 W. Baring St</i>	

Money Hospital

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1924

William O'Connell

10

20. 1924

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6667	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James McCoy</i>		2. DATE AND HOUR OF DEATH <i>6-25-1968 12:20 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i># 21201803</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		8. DATE OF BIRTH <i>8-10-1934</i> 9. AGE (In years lost birthday) <i>33</i>	
11. BIRTHPLACE (State or foreign country) <i>S.C.</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>William</i>		14. MOTHER'S MAIDEN NAME <i>Annie Walker</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. Walker 121 So. Parkin St.</i>	
18. <i>277X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) <i>Malignant Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Marked Obesity</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>287X II</i>		<i>Congestive Heart Failure</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that my (this hospital) attended the deceased from <i>6-17</i> 19 <i>68</i> to <i>6-25</i> 19 <i>68</i> , that we (we) last saw the deceased alive on <i>6-25</i> 19 <i>68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Donald M. Wood, MD</i>		23B. DATE SIGNED <i>6-25-68</i>			
23C. PHYSICIAN'S NAME (Type) <i>Donald M. Wood, M.D.</i>		23D. ADDRESS <i>1213 Light STREET</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/30/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Ebenezer</i>	
24D. LOCATION (City, town, or county)		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 28 1968</i>		25B. NAME OF REGISTRAR <i>Charles E. Farkner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles A. Rice 661 W. Bane</i>	

1101-1102
Baltimore
121 24
8-10-1904
2.0
Annie Walker

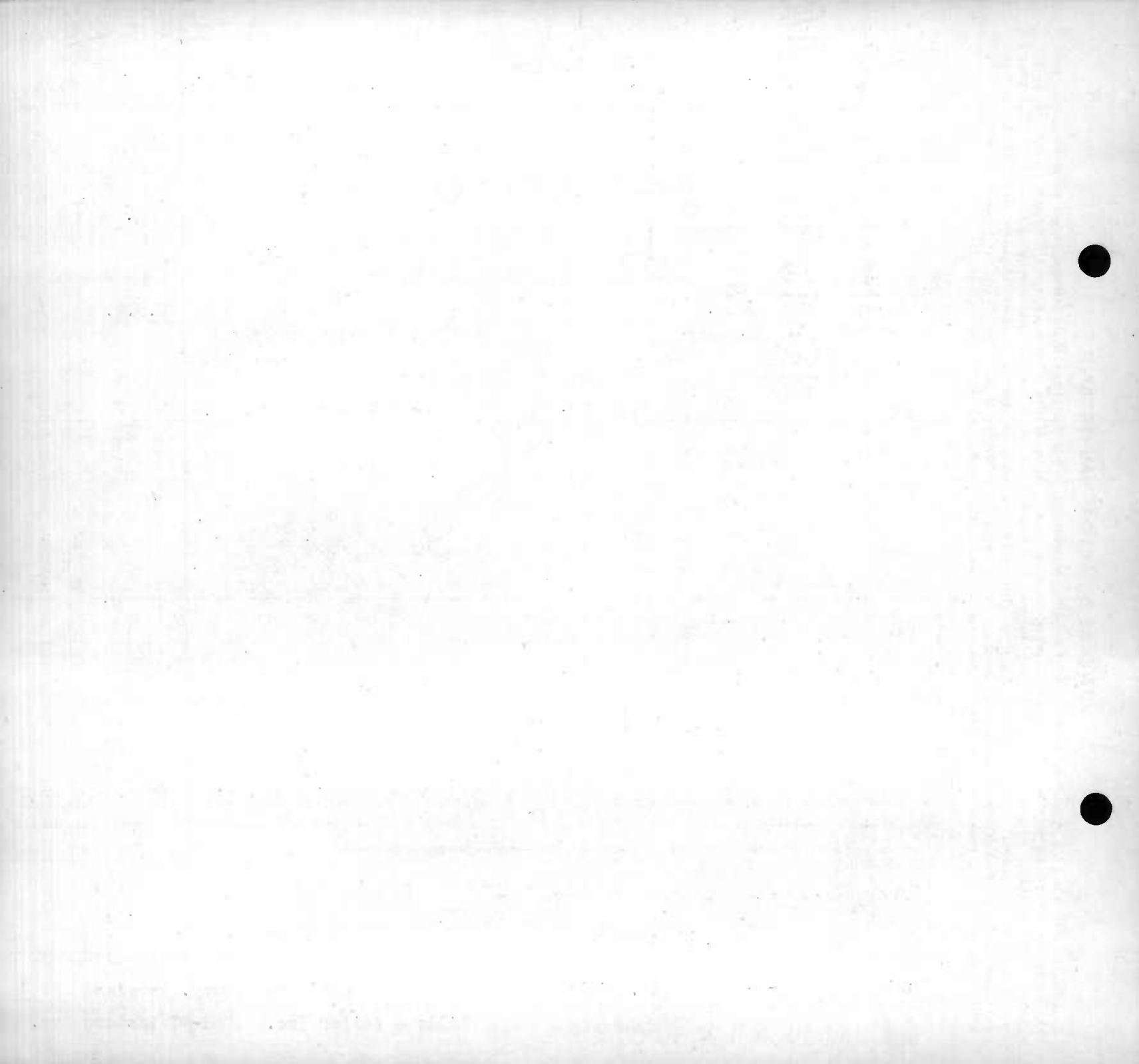
South Baltimore General Hosp
Male Negro
Construction
Willie

Yes

Donald M. Black and Wright Street

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

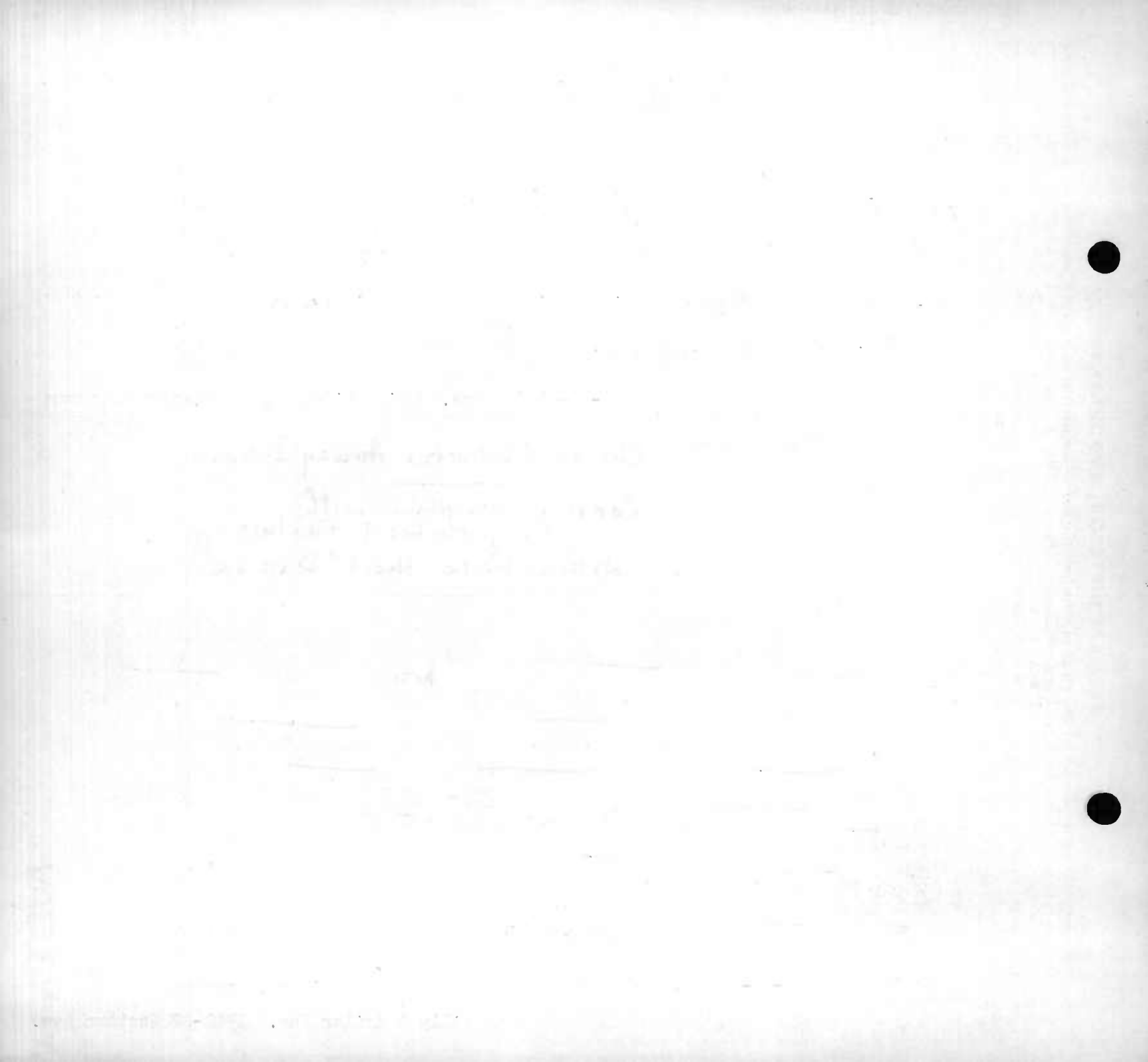
<div style="display: flex; justify-content: space-between;"> R-220 68- 6668 </div> <div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 68- 6668 </div>			
1. NAME OF DECEASED (Type or Print) JOHN. RAKOCZY		2. DATE AND HOUR OF DEATH June 27, 1968 5:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Monticello State Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3112 Fleet St. Balto.	
5. SEX M.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 22, 1925
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Union Carver		11. BIRTHPLACE (State or foreign country) Custina	9. AGE (In years last birthday) 42
13. FATHER'S NAME Alex Rakoczy		14. MOTHER'S MAIDEN NAME Mary Dorozska	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 513-01-	17. INFORMANT ADDRESS Anna Rakoczy Same
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 4640.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 334X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia	
		(B) DUE TO, OR AS A CONSEQUENCE OF: Left Hemiplegia, 9 mo.	
		Arteriosclerosis, 20 yrs.	
		Abscess, Left Flank 1 1/2 mo.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 334X II		20A. AUTOPSY? (Yes or No) NO	
19A. DATE OF OPERATION 5/18/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abscess of FLANK.	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that we (this hospital) attended the deceased from 1-11 19 68 to 6-27 19 68 , that (I) we last saw the deceased alive on 6-27 19 68 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.			
23A. SIGNATURE Raymond W. Herrmann		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) RAYMOND W. HERRMANN		23D. ADDRESS Monticello St Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-1-1968	24C. NAME OF CEMETERY or CREMATORY St. Michael	24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968	25B. NAME OF REGISTRAR Robert E. Tabor	25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
68-6669 CERTIFICATE OF DEATH										
REG. NO. <u>68-6669</u>										
BIRTH NO. <u>W-300</u>		1. NAME OF DECEASED (Type or Print) <u>EDWARD G WHITE</u>				2. DATE AND HOUR OF DEATH <u>6-26 68</u> <u>0.20</u> <u>PM</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hospital</u>					A. STATE <u>Maryland</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY					
					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <u>3609 Greenmount Ave</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20 1900</u>		9. AGE (In years last birthday) <u>67</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitarian Worker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>			11. BIRTHPLACE (State or foreign country) <u>Unknown Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>		
13. FATHER'S NAME <u>Unknown Charles White</u>					14. MOTHER'S MAIDEN NAME <u>Unknown Mary Chrilton</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-40-2746</u>		17. INFORMANT ADDRESS <u>Mrs. Marie White 3609 Greenmount Avenue</u>					
18. <u>412.31</u> CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					Chronic Obstructive Airway Disease					
ANTECEDENT CAUSES					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrhythmia with Congestive Heart Failure					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease					
					(C)					
19. <u>420.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
			While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <u>6-22 68</u> to <u>6-26 68</u> , that (I) (we) last saw the deceased alive on <u>6-26 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Frederick B. Bjornsson</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>6-27 68</u>		
23C. PHYSICIAN'S NAME (Type) <u>Bjornsson</u>					23D. ADDRESS <u>Maryland General Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE			24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>			<u>6-29-1968</u>			<u>Schwartz</u>			<u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS				
<u>JUN 28 1968</u>			<u>Robert E. Taylor</u>			<u>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 6670
5-365		68- 6670		REG. NO. 68- 6670
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Mrs. Ellnora Stroman		6/26/68 8 A M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hosp.		A. STATE Md. B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 2245 E. Biddle St.		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-1917	9. AGE (In years lost birthday) 51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Home	Hamlet, NC	U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Samuel Bass		Queen Pemberton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
NO			Booker T. Stroman 2245 E. Biddle	
18. 206.01 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Monocytic Leukemia 1 wk.		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
204.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes mellitus Years		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/24 1968 to 6/26 1968, that (I) (we) last saw the deceased alive on 6/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Louis E. Genyer M.D. DEGREE		6/26/68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)
Burial	6/30/68	ARBITUS	BALTO	Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS	
JUN 28 1968	Robert E. [unclear]	MORTON + DET F.H.	1701 LAURENS	

1917

Hamlet, NC

Hamlet, NC

Robert T. Brown

At the time of the ...

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-6671	
BIRTH NO. 4-452		68-6671	
M.E. CASE NO.		68-6671	
1. NAME OF DECEASED (Type or Print) HERMAN HOLMES		2. DATE AND HOUR OF DEATH 26 June 1968 10³⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgemere 5300	
D. STREET ADDRESS (If rural, give location) POPPES LANE BOX 2886 21219			
5. SEX MALE	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 2-14-99
9. AGE (In years last birthday) 69		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDDIE		14. MOTHER'S MAIDEN NAME EMMA, WINBRICK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 213-09-2253		16. SOCIAL SECURITY NO. 213-09-2253	
17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) chronic obstructive lung disease cor pulmonale		INTERVAL BETWEEN ONSET AND DEATH > 10 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (2) hemiplegia 2° to CVA. 1964 (3) sided cerebral haematoma.			
19A. DATE OF OPERATION 9964	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (2) cerebral haematoma	20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 14 Nov 1967 to 26 June 1968 , that (we) last saw the deceased alive on 26 June 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.			
23A. SIGNATURE V.A. Lennon		23B. DATE SIGNED June 26, 1968	
23C. PHYSICIAN'S NAME (Type) V.A. Lennnon		23D. ADDRESS 9- BALTIMORE CITY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/1/68	24C. NAME OF CEMETERY or CREMATORY MT. CALVARY	24D. LOCATION (City, town, or county) (State) A.A. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 28 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS MORTON + DYE 1701 LAURENS	

Self Employed

BURIAL 11/02 MT. CALVARY A.A. CO. MD.
MORTON, JEFF 1701 LAWRENCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

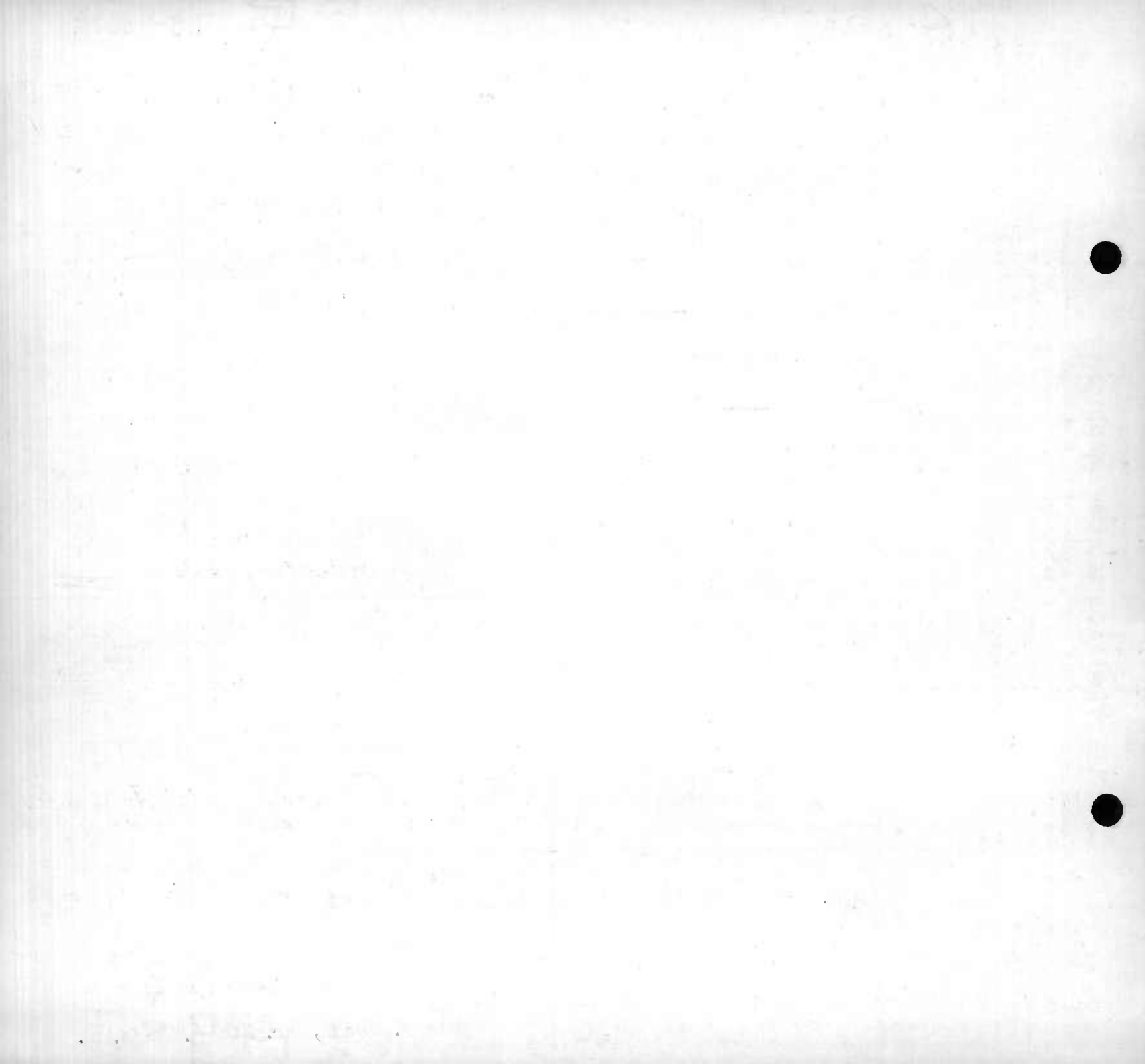
Baltimore City Health Department				REG. NO. 68-6672	
W-452 68-6672 CERTIFICATE OF DEATH		WILLIAMS, Leon Roosevelt June 27, 1968 3:00 A M.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		Maryland			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Barber		Services		Williamston, N.C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Arthur Williams		Minnie Hassell		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes 3/14/51-3/10/53		468-07-1329		VA Hospital Records	
				ADDRESS	
				3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CARDIO RESPIRATORY ARREST		12 hours	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		? Tuberculous peritonitis causing intestinal obstruction			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Bilateral advanced pulmonary tuberculosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
002.1 II				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Nat While <input type="checkbox"/>		At Work <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from June 6th 19 68 to June 27th 19 68, that (1) (we) last saw the deceased alive on June 27th 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
		N. S. J. adu.		June 27, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				Hassel Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 28 1968		Robert E. Taylor		1701 Laurens Street Morton & Dyett Funeral Home	

BIRTH NO. <u>68-10623</u>		BALTIMORE CITY HEALTH DEPARTMENT		68-6673	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) JO ANNE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968		Hour 2:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 23, 1968		Hour 7:35 P.M.	
6. SEX female		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 4, 1968		10. AGE (In years lost birthday) 19		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? Yes		13. FATHER'S NAME Joseph Boston		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N. A.	
15. MOTHER'S MAIDEN NAME Jane Little		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N. A.		17. SOCIAL SECURITY NO. None	
18. INFORMANT Jane Boston		19. CAUSE OF DEATH Congenital Heart Disease		20. ADDRESS 1821 Kavanaugh Street	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Congenital Heart Disease		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE		23. DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 734.5		25. DATE OF OPERATION 6-28-68		26. CONDITION FOR WHICH OPERATION WAS PERFORMED Mount Auburn Cemetery	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Baltimore, Maryland		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore, Maryland	
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) June 23, 1968		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR? Yes	
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE Werner U. Spitz, M.D.		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
36. DATE SIGNED 6/24/68		37. DATE REC'D BY HEALTH DEPT. JUN 28 1968		38. NAME OF REGISTRAR Morton & Dyett	
39. DATE OF BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 6-28-68		41. LOCATION (City, town, or county) (State) Baltimore, Maryland	
42. DATE REC'D BY HEALTH DEPT. JUN 28 1968		43. NAME OF REGISTRAR Morton & Dyett		44. ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6674
G-635		68-6674 CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CAROLYN F GORDON		2. DATE AND HOUR OF DEATH June 27, 1968 4:00 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Carroll 21784		
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital M.G.H.		C. CITY OR TOWN SYKESVILLE	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER Rt 1, Box 33 A. 5600		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/97.	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES BANKS		14. MOTHER'S MAIDEN NAME CARRIE Smith.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT CHART.	
18. 410.9		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CARDIAC STANASIS 6 minutes
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		3 days
		(C) ASCVD, & CORONARY THROMBOSIS		years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Hypothyroidism				years
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner) ---	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---		
21D. TIME OF INJURY (APPROX.) ---	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? ---		
22. I certify that (1) (this hospital) attended the deceased from 6/24 1968 to 6/27 1968 , that (1) (we) last saw the deceased alive on 6/27 1968 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ann R. Wicke		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/27/68
23C. PHYSICIAN'S NAME (Type) ANN R WICKE		23D. ADDRESS M.G.H.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/29/68	24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith Cem	24D. LOCATION (City, town, or county) (State) Baltimore County	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968	25B. NAME OF REGISTRAR Robert E. Fairman	25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto. St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6675
W-256 68-6675 CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Adeleine C. Wagner		2. DATE AND HOUR OF DEATH 6-26-68		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 9-08		
FULL NAME OF HOSPITAL OR INSTITUTION 94700 Harford Ave.		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 709 BALLET HILL		
5. SEX F.	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-88	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.
13. FATHER'S NAME John W. Tietzening		14. MOTHER'S MAIDEN NAME Ida Watkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family - Jane
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1958 19 to June 26 19 68 , that (I) (we) last saw the deceased alive on June 25 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Loy M. Zimmerman MD		23B. DATE SIGNED 6/27/68		23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman M.D.
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 6/19/68		24C. NAME OF CEMETERY or CREMATORY Harford Rd, Baltimore, MD
24D. LOCATION (City, town, or county) (State) BALTIMORE		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		
25B. NAME OF REGISTRAR Robert E. Tietzening		25C. FUNERAL DIRECTOR McCully - 130 E Fort Col.		

22

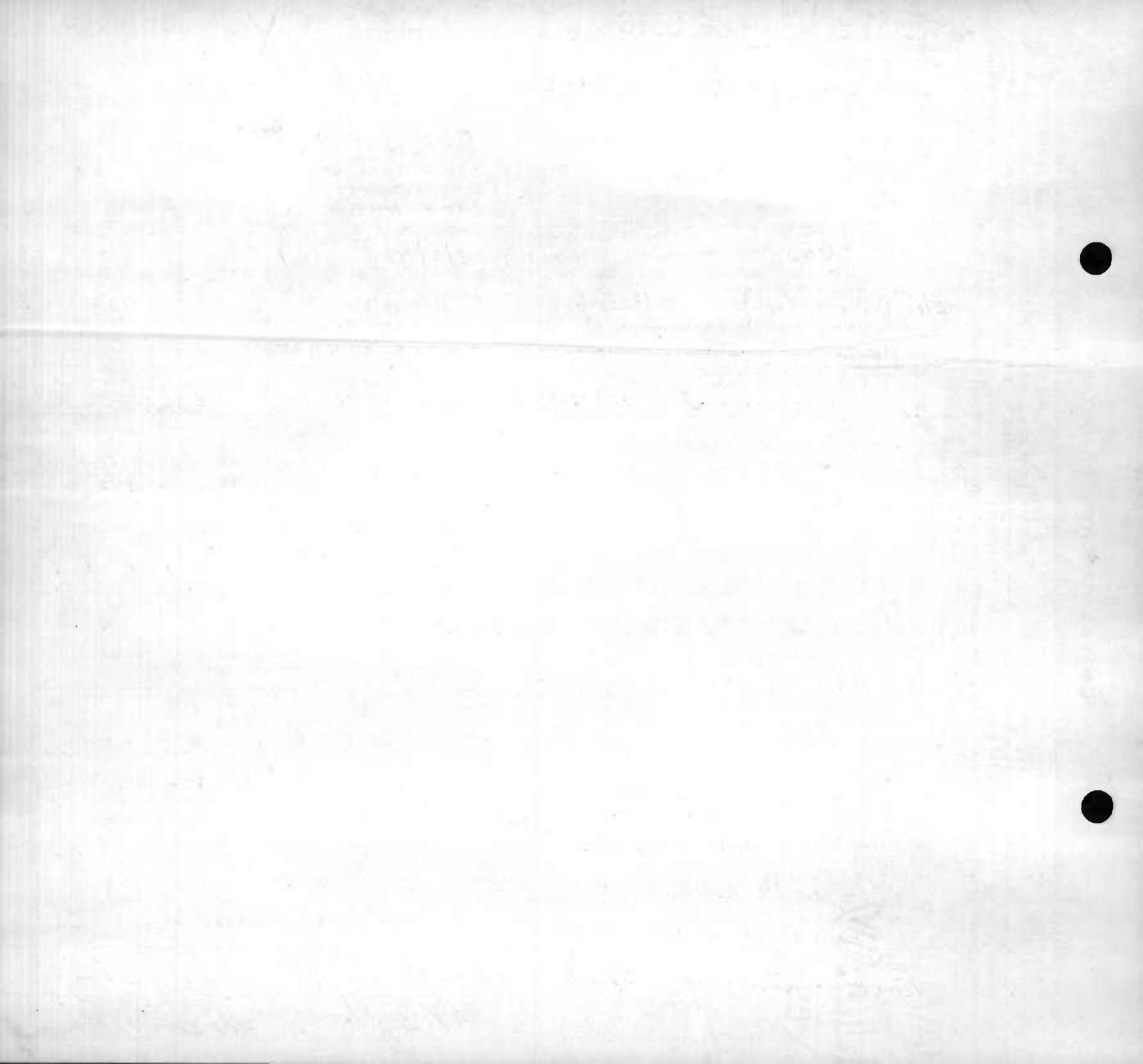


W. G. L. 100-100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6676	
<div>5-315 68-6676</div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WALTER CHRISTIAN STEFFEN		6/26/68 1:25 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNIV. OF MD. HOSPITAL			MD. Anne Arundel		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			LINTHICUM HTS.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			108 NURSERY RD.		52-00
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	CAU.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3/3/99	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Elec. Contractor (ret.)		Self Emp.		GERMANY	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HENRY STEFFEN			MARIE DICKMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			217-16-8869		Mr. Herbie Steffen (son) Glen Burnie, Md.
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					3 wks
BILATERAL ASPIRATION PNEUMONIA					
(B) THYROID CARCINOMA & WIDESPREAD METASTASES					UNKNOWN
(C)					
194X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					6 months
MALABSORPTION SYNDROME					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
5/28/68		THYROID CARCINOMA		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/14 1968 to 6/26 1968, that (I) (we) last saw the deceased alive on 6/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronica M. Kluge, M.D.				6/26/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RONICA M. KLUGE, M.D.				UNIV. HOSP., BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 29, 1968		Glen Haven Mem. Park	
				24D. LOCATION (City, town, or county) (State)	
				Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1968		Robert E. Fashina		R.V. Singleton Singleton Funeral Home Glen Burnie, Md.	



D-200

68-6677

BALTIMORE CITY HEALTH DEPARTMENT

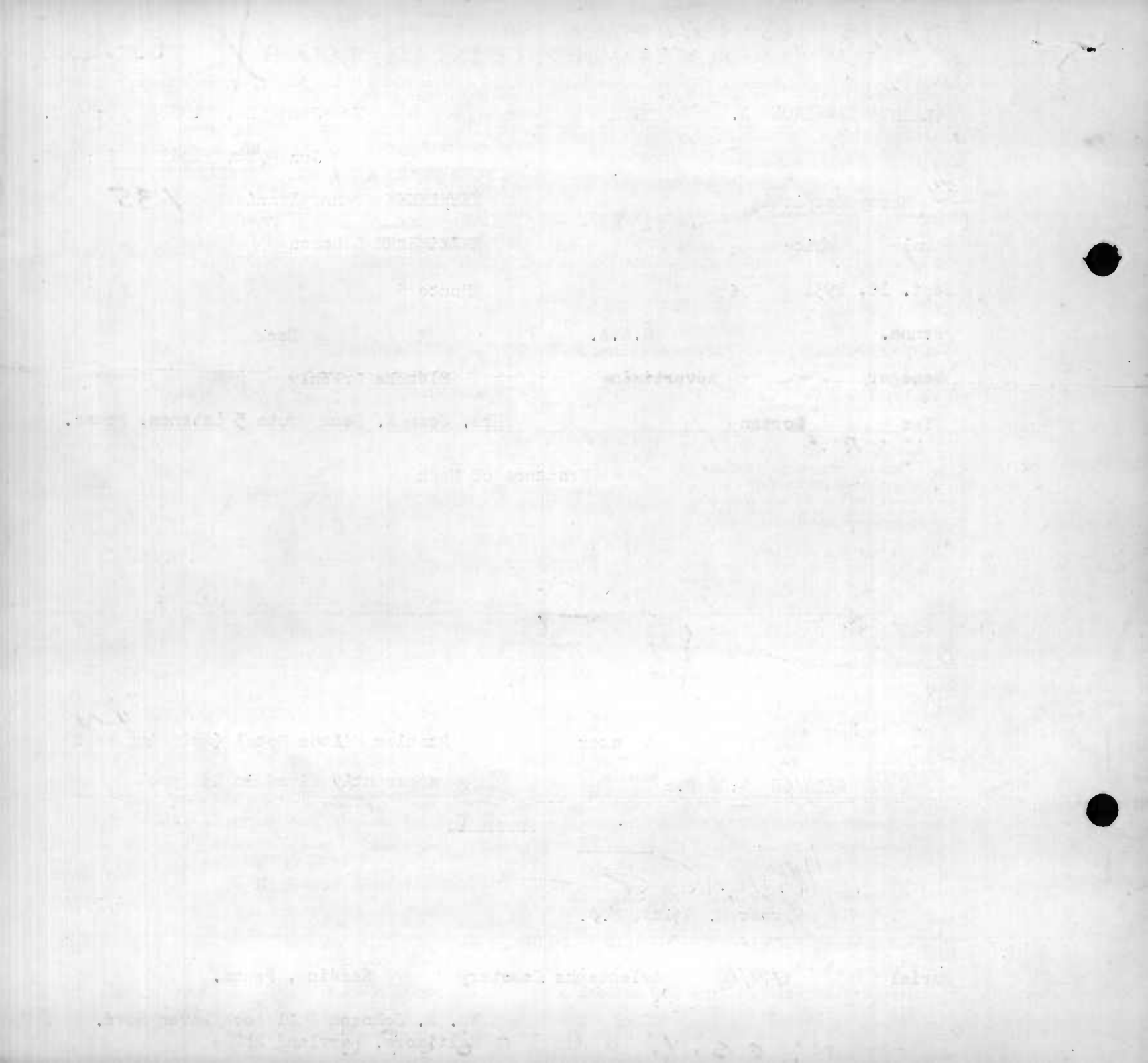
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-6677

BIRTH NO.

REG. NO.

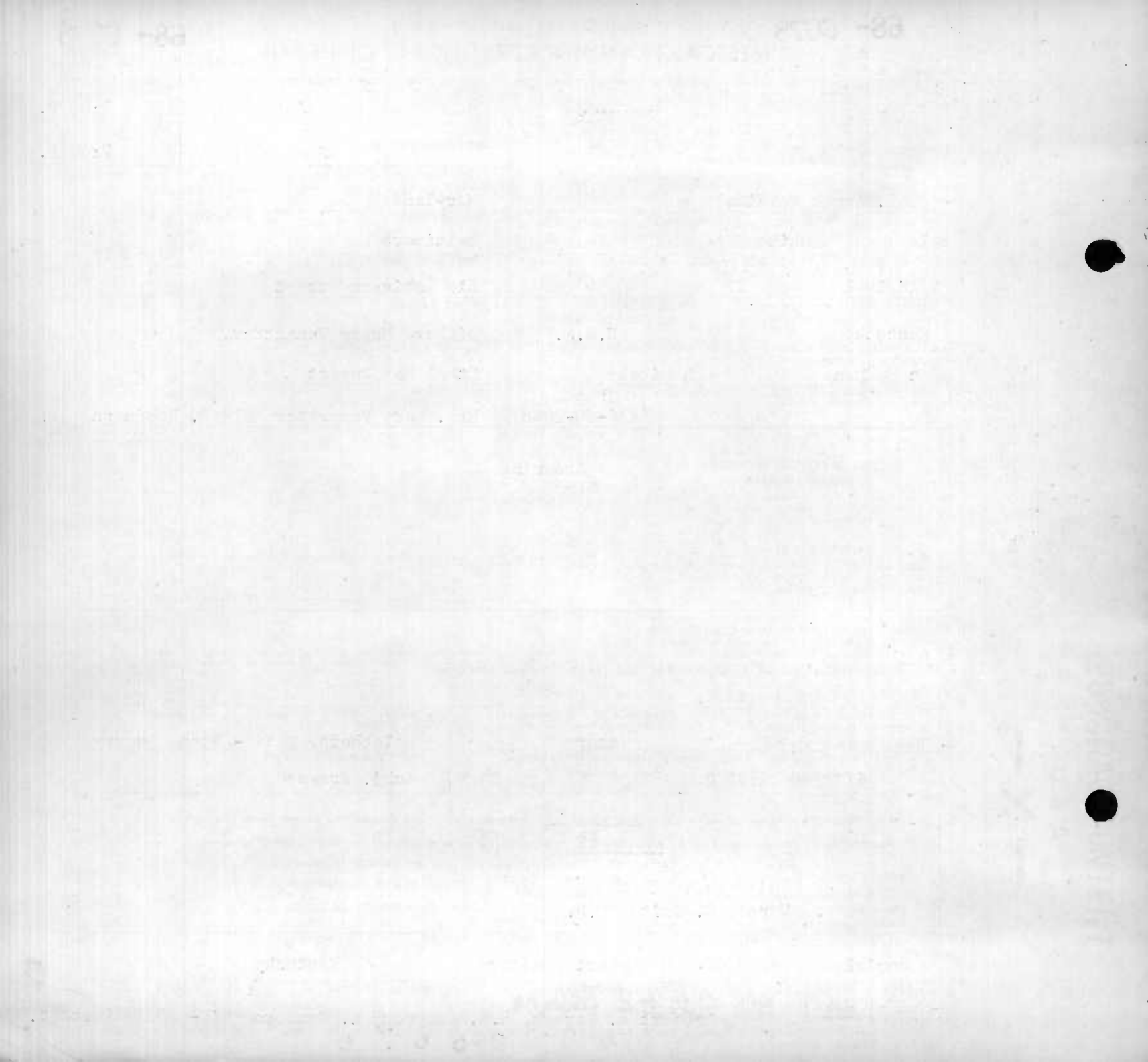
1. NAME OF DECEASED (Type or Print) (LARRY) LAWRENCE A. DECK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 24, 1968 Hour 6:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year June 24, 1968 Hour 10:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE PA B. COUNTY WYOMING		C. CITY OR TOWN Lebanon D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX male	7. RACE white	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 10, 1931		10. AGE (In years lost birthday) 36 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		14B. KIND OF BUSINESS OR INDUSTRY Advertising	
15. MOTHER'S MAIDEN NAME Blanche Greenly		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Joan A. Deck	
19. E8831 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Fracture of Neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		20. DATE OF OPERATION 8	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Statler Hilton Hotel (swimming pool)	
22D. TIME OF INJURY (APPROX.) 6/24/68 6:30 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? apparently dived in pool		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6/25/68		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 6/28/68		24C. NAME of CEMETERY or CREMATORY Aulenbachs Cemetery	
24D. LOCATION (City, town, or county) (State) Reading, Penna.		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1968	
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Wm. E. Johnson	
25D. ADDRESS 8521 Loch Raven Blvd. Baltimore, Maryland 21204			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.		REC'D NO.	
1. NAME OF DECEASED (Type or Print) GARY VANNATTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 23, 1968 Hour 7:40 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1968 7:40 P.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/18/1941		10. AGE (In years last birthday) 27	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Moore Vannatter		14. MOTHER'S MAIDEN NAME Ethel Mae Enyart	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Set Up Man		16. KIND OF BUSINESS OR INDUSTRY Chemical	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 236-60-2048	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Drowning (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E. 910.9 I F. 929.2 II		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) _____ (B) _____ (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____	
21. DATE OF OPERATION 6/23/68		22. CONDITION FOR WHICH OPERATION WAS PERFORMED water	
23. AUTOPSY? (Yes or No) No		24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING	
25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Halethorpe Road - Stone Quarry	
27. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6/23/68 6:28 P.		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
29. HOW DID INJURY OCCUR? subj. drowned		30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
31. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. DATE SIGNED 6/24/68		34. BURIAL CREMATION, REMOVAL (Specify) burial	
35. DATE 6/28/68		36. NAME OF CEMETERY OR CREMATORY Lybert Cemetery	
37. LOCATION (City, town, or county) (State) Kentucky		38. DATE REC'D BY HEALTH DEPT. July 1, 1968	
39. NAME OF REGISTRAR Robert E. Farber, M.D.		40. FUNERAL DIRECTOR Raymond L. Kaczorowski - 2525 Fleet St.	



V-536 68-6678 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6678

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GARY VANNATTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour June 23, 1968 7:40 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 23, 1968 7:40 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 7-01	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 2-18-1941 27		10. AGE (In years lost birthday) 27		E. STREET AND NUMBER 819 Robinson Street	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RICHARD MOORE VANNATTER	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SET UP MAN		14B. KIND OF BUSINESS OR INDUSTRY CHEMICAL		15. MOTHER'S MAIDEN NAME ETHEL MAE ENYART	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO.		17. SOCIAL SECURITY NO. 236-60-2048		18. INFORMANT MRS. MARY VANNATTER ADDRESS 819 S. ROBINSON ST.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Drowning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) water		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Halethorpe Road - Stone Quarry	
22D. TIME OF INJURY (APPROX.) 6/23/68 6:28 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? subj. drowned	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/24/68	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-28-1968		24C. NAME OF CEMETERY or CREMATORY CLYBERT CEMETERY	
24D. LOCATION (City, town, or county) (State) RUSH KENTUCKY					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Fajana		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI ADDRESS 2525 FLEET ST.	

Chemical. Ethyl Mercaptan

FUNERAL DIRECTOR: IMPORTANT

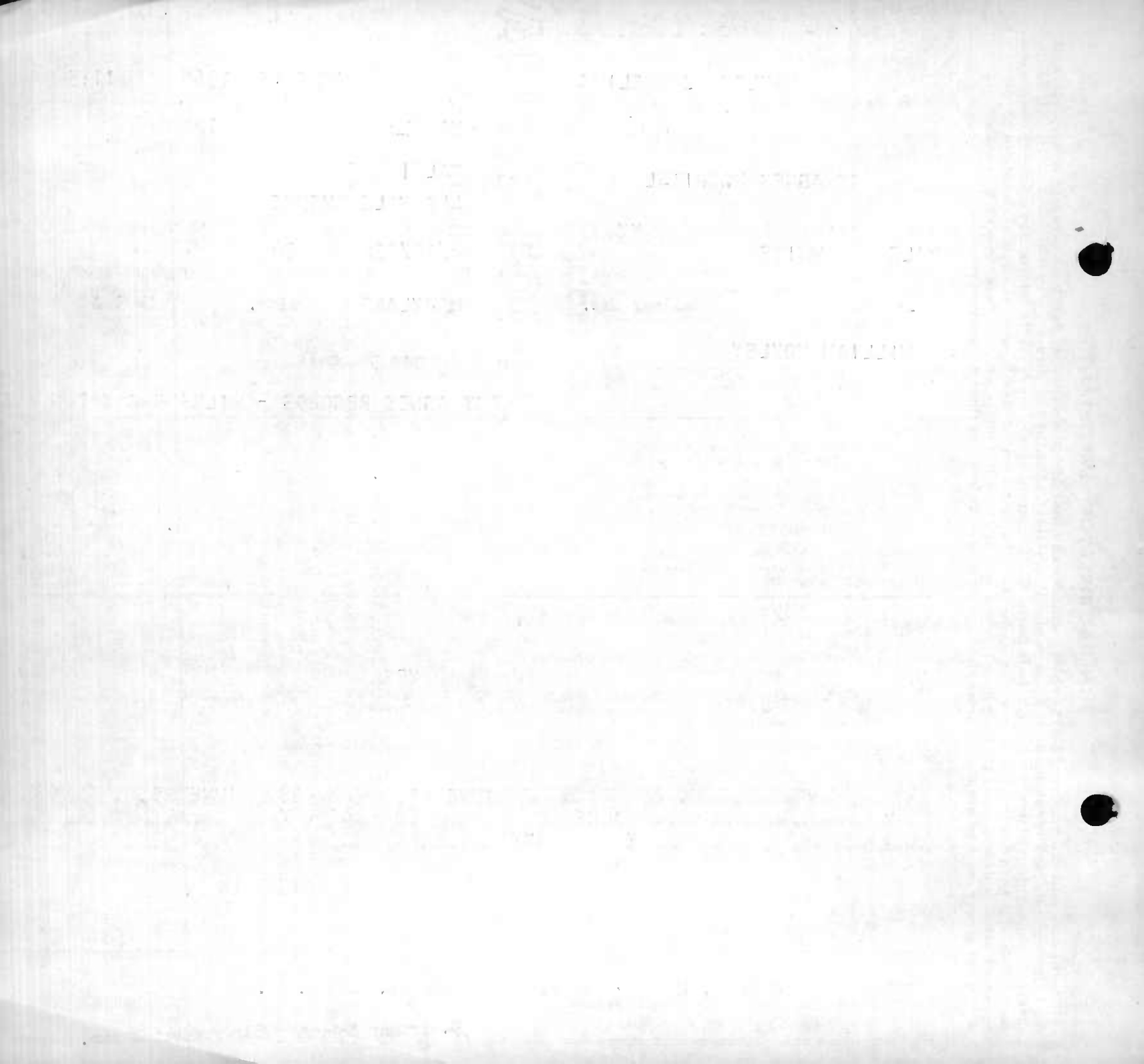
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6679	
BIRTH NO. B-432		68- 6679 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HELEN BIELANSKI			2. DATE AND HOUR OF DEATH JUNE 23 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2111 GOUGH STREET			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2111 GOUGH STREET		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 28 1902	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAND WORKING		10B. KIND OF BUSINESS OR INDUSTRY LEBOW BROS. INC.		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANDREW BIELANSKI			14. MOTHER'S MAIDEN NAME MARCELLA DRACZ		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-5475		17. INFORMANT MR. THADDEUS BIELANSKI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 183.01 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MULTIPLE Adenocarcinoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (Resident spread to lungs, mouth + other organs) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cystic adenocarcinoma - ovaries - bilateral + uterus + cervix in 1955		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years			
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 8 1955 to June 23 1968 , that (I) was lost saw the deceased alive on June 19 1968 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE Sigmund R. Nowak M.D.				23B. DATE SIGNED June 26, 1968	
23C. PHYSICIAN'S NAME (Type) SIGMUND R. NOWAK M.D.				23D. ADDRESS 408 S. PATTERSON PK. AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-1968		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY	
24D. LOCATION (City, town, or county) BALTIMORE		24E. STATE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Jarbo		25C. FUNERAL DIRECTOR ADDRESS RAYMOND L. KACZOROWSKI 2525 FLEET ST	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
M-240		MOXLEY, CORNELIUS		JUNE 25, 1968 11:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			A. STATE MARYLAND B. COUNTY 21229		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 445 YALE AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/19/93	9. AGE (In years lost birth day) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Railway Exp.		11. BIRTHPLACE (State or foreign country) MARYLAND Balto.	
13. FATHER'S NAME WILLIAM MOXLEY		14. MOTHER'S MAIDEN NAME Johanna Scannell		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1918		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES RECORDS - WILKENS & CATON AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism few minutes (B) DUE TO, OR AS A CONSEQUENCE OF: Gen. peritonitis 2 days (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 23, 19 68 to JUNE 25, 19 68, that (X) (we) last saw the deceased alive on JUNE 25, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. Jimenez Jr. M.D. 23B. DATE SIGNED 6-25-68				23C. ADDRESS 4720 Melborne Rd Balto. 21254	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 28, 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park National Cem. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave.	



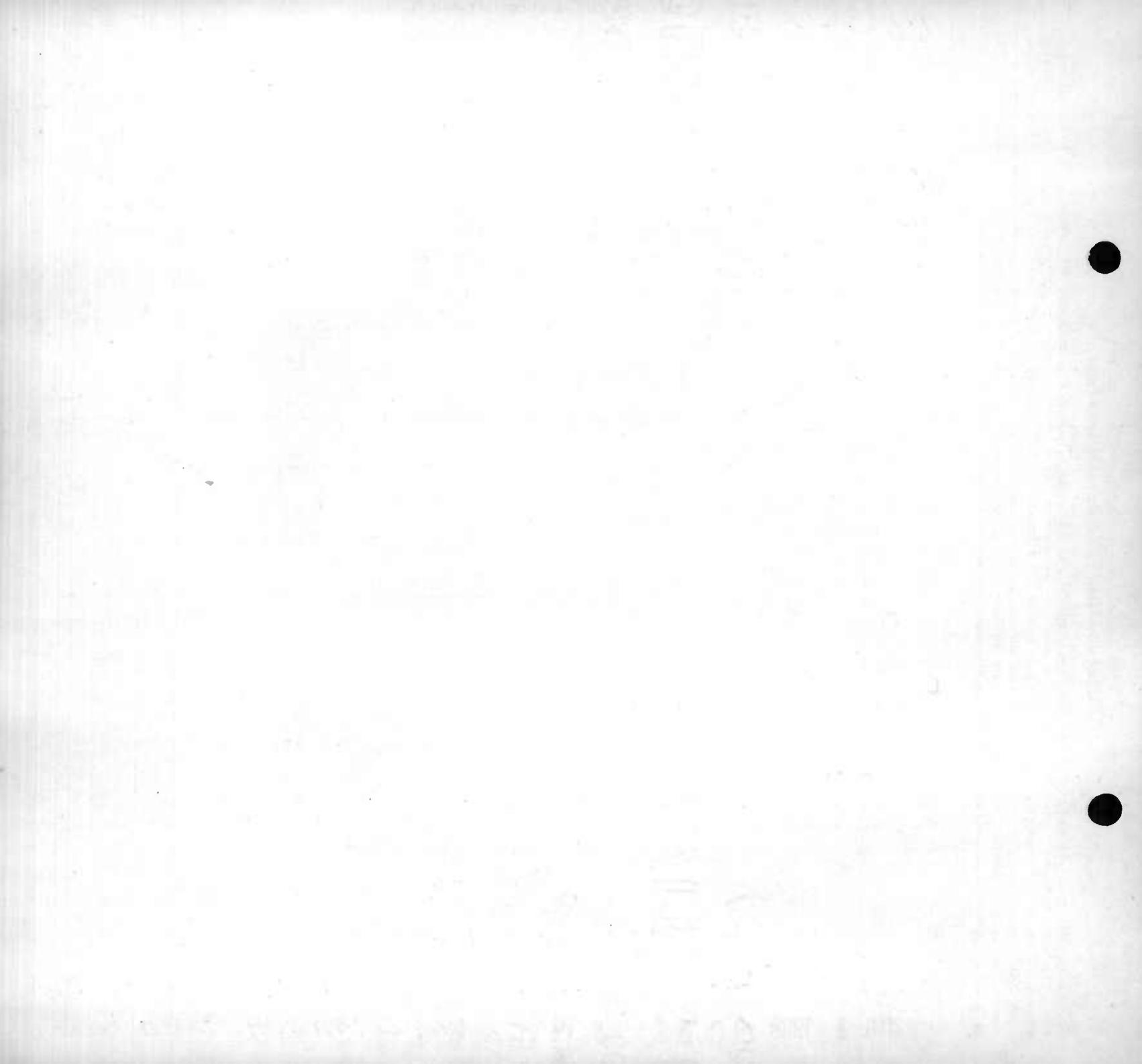
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-652		68-6681		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Arthur James Torrence</u>			
2. DATE AND HOUR OF DEATH <u>June 26, 1968, 9:45 A.M.</u>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 1604 Chesapeake Ave</u>				A. STATE <u>md.</u> B. COUNTY			
5. SEX <u>male</u>				6. RACE <u>negro</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>				8. DATE OF BIRTH <u>June 17, 1893</u>			
9. AGE (In years lost birthday) <u>75</u>				10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
11. BIRTHPLACE (State or foreign country) <u>Salisbury, N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Torrence</u>				14. MOTHER'S MAIDEN NAME <u>Annie Baker</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-05-7684</u>			
17. INFORMANT <u>Ada Jennings</u>				ADDRESS <u>340 Bloom St</u>			
18. <u>582X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>U Remia</u> <u>chr. Nephritis</u> <u>Debility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 mo.</u>			
19. <u>592X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arterio Sclerotic Heart</u>				12 yrs.			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>0</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>March 25, 1968</u> to <u>June 26, 1968</u> . that (I) (we) last saw the deceased alive on <u>June 26, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jerry C. Luck</u>				23B. DATE SIGNED <u>June 26, 1968</u>			
23C. PHYSICIAN'S NAME (Type) <u>Jerry C. Luck</u>				23D. ADDRESS <u>427 Swale Rd, Balto md 21225</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7-1-68</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Ann Arundel Cty, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Farber</u>			
25C. FUNERAL DIRECTOR <u>Wm C. MARCH</u>				ADDRESS <u>928 E. NORTH Ave</u>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6682	
M-560 68- 6682 CERTIFICATE OF DEATH					
BIRTH NO. 1					
1. NAME OF DECEASED (Type or Print) MINER SADIE			2. DATE AND HOUR OF DEATH June 25th 1968 7-20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran hospital 730, Ashburton. Baltimore Md. 21216			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3300, Alto Rd. 21216		
5. SEX F	6. RACE Coloured	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1883	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		
16. SOCIAL SECURITY NO.			17. INFORMANT JESSE - SON. ADDRESS 945-6296		
18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic heart disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Renal failure			(B) DUE TO, OR AS A CONSEQUENCE OF: Toxic Nodular goitre		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 2-20-1968 to 6-25-1968 , that (I) (we) last saw the deceased alive on 6-25-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BIPIN DESAI			23B. DATE SIGNED June 25th 68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) BIPIN. DESAI M.D.			23D. ADDRESS 46 Lutheran hospital.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-1-68	24C. NAME of CEMETERY or CREMATORY Mt. Calvary cem.		24D. LOCATION (City, town, or county) (State) Ann Arundel City Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS WM C. MARCH 928 E NORTH AVE	



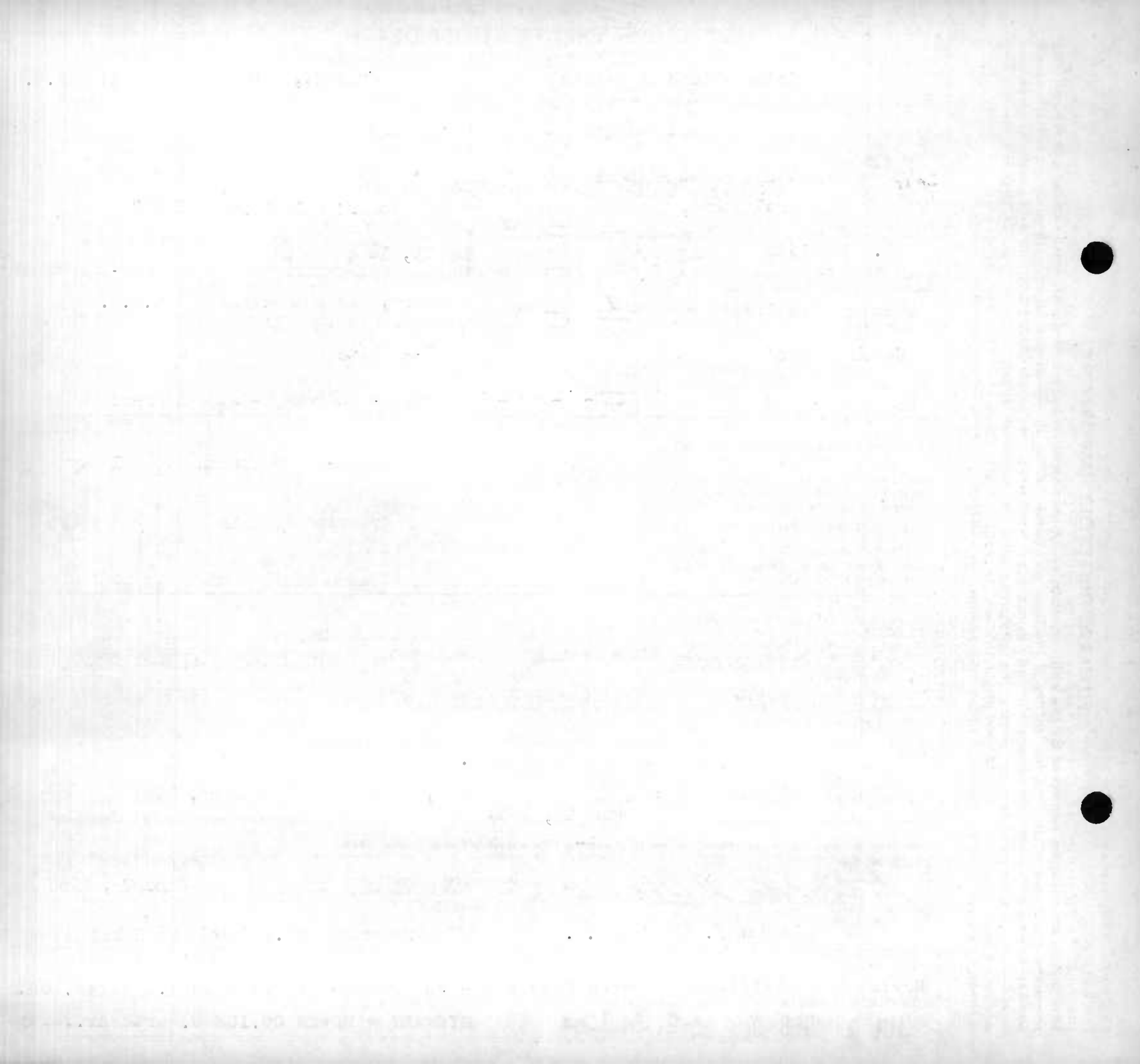
W-425-68-6683 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6683

BIRTH NO.		1. NAME OF DECEASED (Type or Print) OLIVIA M. WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968 Hour 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2231 Barclay Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 24, 1968 Hour 12:30 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6-26-09		10. AGE (In years lost birthday) 57		E. STREET AND NUMBER 2231 Barclay Street	
11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Ransom	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Olivia Griffin 2231 Barclay St. 21218	
19. 4/2.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/24/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-28-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr. 1735 Harford Avenue 21213			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

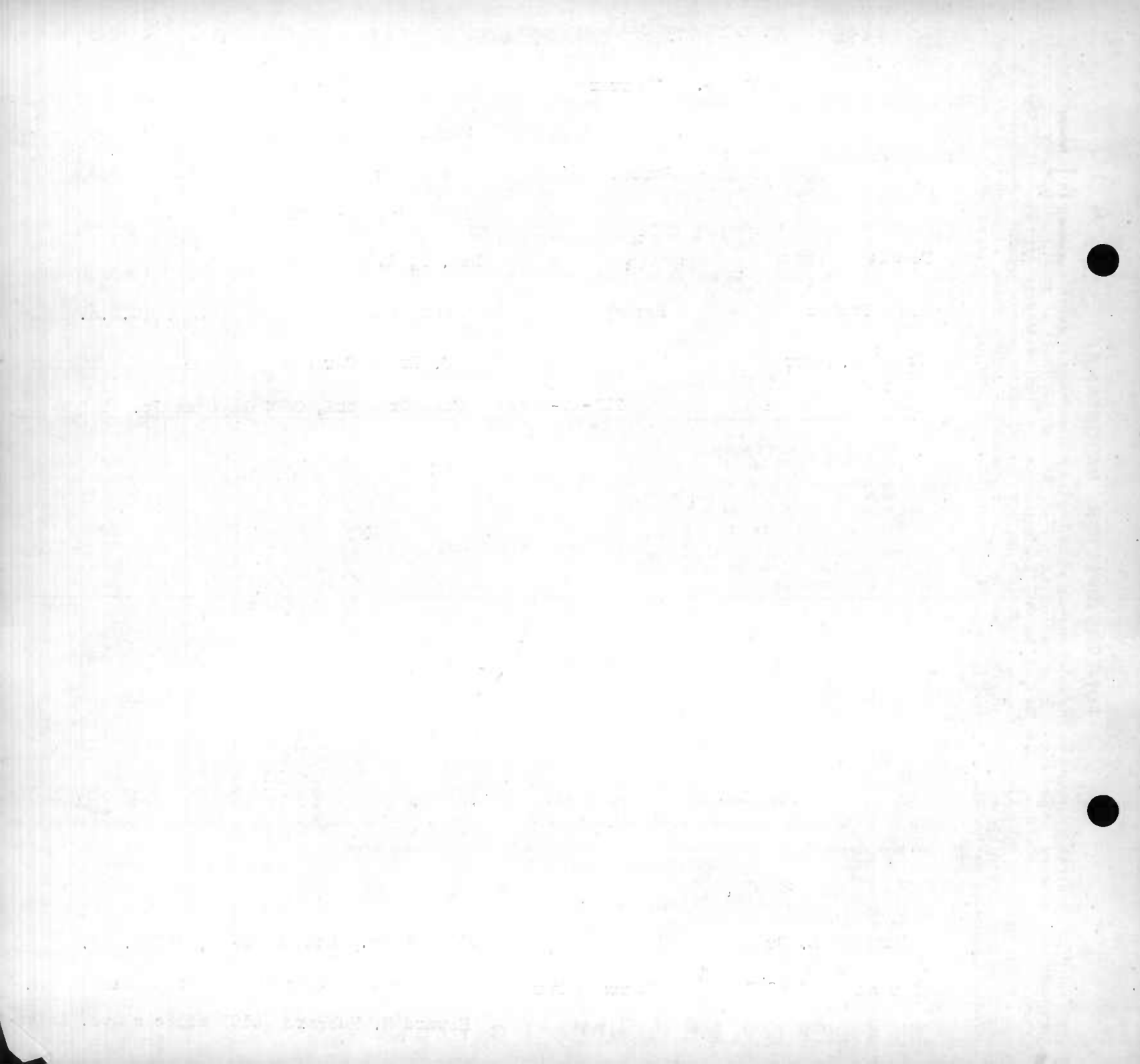
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6684	
<div style="display: flex; justify-content: space-between;"> M-320 68- 6684 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH June 29, 1968 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland City C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road 21207			
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1884	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (retired)		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Roxbury, Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jacob Mathis		14. MOTHER'S MAIDEN NAME Julia White	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-0676-J1		17. INFORMANT ADDRESS Sister Andrea - same address	
CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 8 years	
19. DATE OF OPERATION None				20. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from March, 1960 19 to June, 1968 19, that (I) (we) last saw the deceased alive on June 25, 1968 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Damian P. Alagia				23B. DATE SIGNED June 29, 1968	
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.				23D. ADDRESS 3326 Frederick Ave., Baltimore 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/1968		24C. NAME OF CEMETERY or CREMATORY Seton Cemetery - on grounds of Seton Inst., Balto., Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av., City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-660</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6685</u>			
1. NAME OF DECEASED (Type or Print) <u>Edith V. Sharrer</u>						2. DATE AND HOUR OF DEATH <u>June 28, 1968</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5006 Division Street 21207</u>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>					
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Dec. 5, 1919</u>			9. AGE (In years last birthday) <u>48</u>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Packer</u>						11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James A. Kerr</u>						14. MOTHER'S MAIDEN NAME <u>G. Irene Garlock</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>217-12-9036</u>			17. INFORMANT ADDRESS <u>Gene Crocetti, 3802 Bayonne St. 21206</u>		
18. <u>175.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CANCER OF OVARY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. DATE OF OPERATION <u>FEB 1968</u>						20. AUTOPSY? (Yes or No) <u>NO</u>			21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>JUN 1968</u> to <u>JUNE 28 1968</u> , that (I) (we) last saw the deceased alive on <u>JUNE 28 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Francis L. Grumbine MD.</u>						23B. DATE SIGNED <u>6/28/68</u>			23C. PHYSICIAN'S NAME (Type) <u>Francis L. Grumbine MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>						24B. DATE <u>7-2-68</u>			24C. NAME of CEMETERY or CREMATORY <u>Lorrane Park</u>		
24D. LOCATION (City, town, or county) (State) <u>Woodlawn Baltimore Md.</u>						25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>					
25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>						25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard 4107 Wilkens Ave. Balto</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6686	
<div style="display: flex; justify-content: space-between;"> Z-220 68-6686 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) ZAKSZEWSKI, VERONICA		2. DATE AND HOUR OF DEATH 6/27/68 12¹⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 217 S. Collington Avenue			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-25-95	9. AGE (In years last birthday) 73	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME JOSEPH WOSK		14. MOTHER'S MAIDEN NAME ROSE KROPATAK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 218-07-3375A		17. INFORMANT Mr. Walenty Zakszewski, 217 S. Collington Ave HOSPITAL CHART	
18. 470.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ORDINARY INSUFFICIENCY (B) DUE TO, OR AS A CONSEQUENCE OF: HYPERTENSIVE CARDIOVASCULAR DISEASE (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 5/23 1968 to 6/27 1968 , that (I) (<u>we</u>) last saw the deceased alive on 6/27 1968 and that in (<u>my</u>) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE Dr. Aramaga, M.D.				23B. DATE SIGNED 6/27/68	
23C. PHYSICIAN'S NAME (Type) DR. ARAMAGA (ATTENDING PHY.)		23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Sadowski		25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE	

THE
FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR THE DIRECTOR: [Illegible]

ADMINISTRATIVE: [Illegible]

INVESTIGATIVE: [Illegible]

LEGAL: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

APPROVED: [Illegible]

FUNERAL DIRECTOR: IMPORTANT

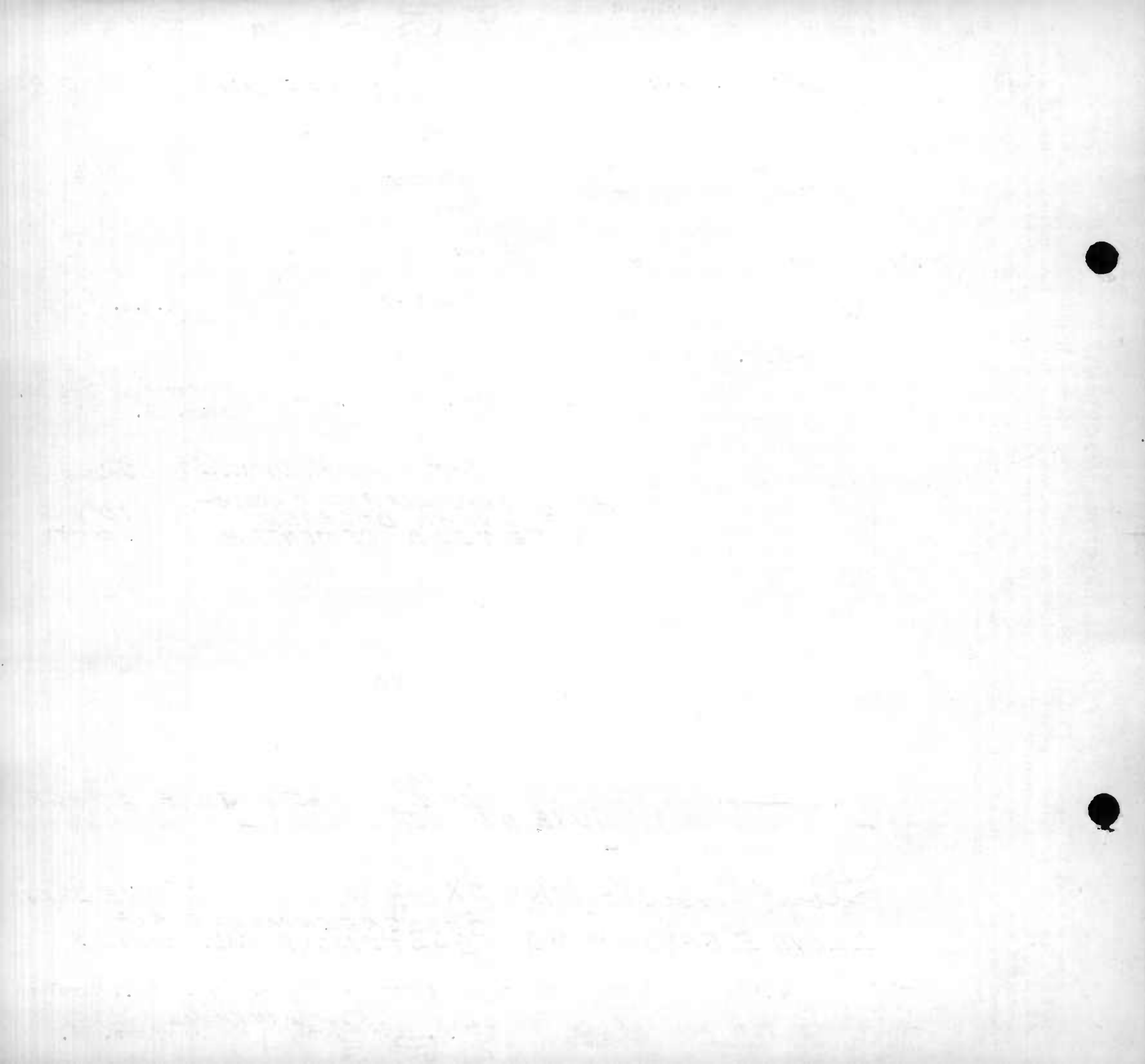
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6687
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Mary A. Markland		2. DATE AND HOUR OF DEATH June 25, 1968 3:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in the Pines - Belvedere		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7. STREET AND NUMBER 120 Raspe Avenue- 21206 53-00		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1889	9. AGE (In years lost birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Anthony Pfarr		
14. MOTHER'S MAIDEN NAME Matilda Schissler		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mildred F. Moore - 120 Raspe Avenue ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.21 + 230.7 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension c.v. D (B) nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF: a30terma (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 20 yrs 1 yr. 15 yrs
19A. DATE OF OPERATION 442 X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 8/15 19 41 to 6/25 19 68 , that (I) (we) last saw the deceased alive on 6/25 19 68 and that in (my) (our) opinion death occurred on the date 6/25 19 68 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
23A. SIGNATURE Isadore K. Grossman		23B. DATE SIGNED 6/25/68		23C. PHYSICIAN'S NAME (Type) Isadore K. Grossman
23D. ADDRESS 1527 E. North Ave		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6-28-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		
25B. NAME OF REGISTRAR Rene E. Taylor		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 ADDRESS Belair Rd. 21206		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

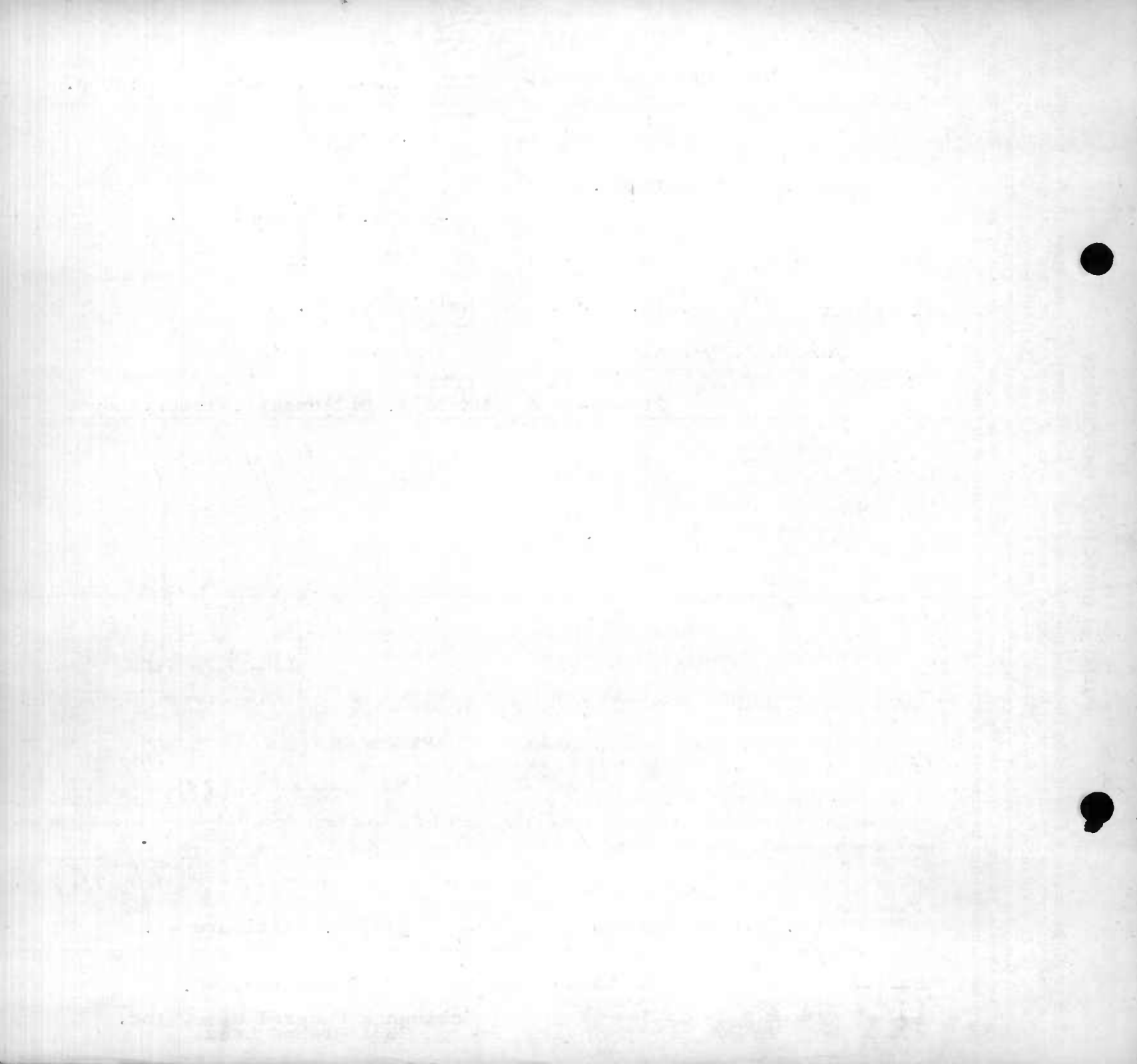
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>68-6688</u>
BIRTH NO. <u>M-620</u>		68-6688		
1. NAME OF DECEASED (Type or Print) <u>Lilah B. Myers</u>		2. DATE AND HOUR OF DEATH <u>JUNE 27, 1968</u> <u>6:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Carroll</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>House of the Pines Nursing Home</u> <u>2525 West Belvedere Avenue</u>		C. CITY OR TOWN <u>Uniontown</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <u>Female</u>		6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/1/1886</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years lost birthday) <u>81</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel D. Heltibridle</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bowersox</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Albert P. Tucker</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>422.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>BRONCHO-PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u> (B) <u>SENILE DEMENTIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 YRS</u> <u>5 YRS</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>JAN.</u> 19 <u>65</u> to <u>JUNE 27</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>JUNE 21</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lloyd E. Saylor, M.D.</u>		23B. DATE SIGNED <u>JUNE 27, 1968</u>		23C. PHYSICIAN'S NAME (Type) <u>LLOYD E. SAYLOR M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Uniontown Lutheran Cemetery</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fabela</u>		25C. FUNERAL DIRECTOR <u>C.O. Fuss & Son</u>
25D. ADDRESS <u>Uniontown, Carroll Co., Maryland</u>		25E. ADDRESS <u>Taneytown, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6689	
BIRTH NO. D-654		68- 6689 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SYLVESTER JOHN DRIMAL		June 26, 1968		6:50 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3402 E. Fairmount Ave.			A. STATE Md., 21224		
			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3402 E. Fairmount Ave.		
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/05	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Mill Wright		Beth. Steel		Baltimore, Md.	
13. FATHER'S NAME Joseph F. Drimal			14. MOTHER'S MAIDEN NAME Hannah Hlavin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-1696		17. INFORMANT Marie A. DiClementi, sister, above	
18. 189.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary of Left Artery</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
180X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>6/26</u> 19 <u>68</u> , that (I) (we) lost saw the deceased olive on <u>6/25</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Julius Goodman</i>			23B. DATE SIGNED 6/27/68		
23C. PHYSICIAN'S NAME (Type) Dr. Julius Goodman			23D. ADDRESS 3400 E. Baltimore St.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		MILTON HAYWARD MC CAULEY		2. DATE AND HOUR OF DEATH June 26, 1968 8:30 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN	
00 3339 Dudley Ave.		Md., 21213		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		3339 Dudley Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months; Days
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/3/99	69	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Elec. Engineer		Bas & Elec. Co.		Washington, D. C.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Milton E. Clarence M. McCauley		Ida Reever Ida V. Reaver			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		212-05-4740		Anita Brack McCauley, wife, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:		15 yrs	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 53 to 19 68, that (I) (we) lost saw the deceased olive on June 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Walter B. Buck		6/27/68		Dr. Walter B. Buck	
23D. ADDRESS		23E. FUNERAL DIRECTOR ADDRESS		23F. NAME OF REGISTRAR	
18 E. Eager St.		Schimunek Funeral Home, Inc.		Robert E. Fick	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/1/68		Lorraine Park	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		JUL 1 1968		Schimunek Funeral Home, Inc.	
24G. ADDRESS		24H. NAME OF REGISTRAR		24I. DATE REC'D BY HEALTH DEPT.	
3331 Brehms Lane		Robert E. Fick		JUL 1 1968	

Birth Certificate of Deceased from Wash. D.C.
and Widow's Affidavit 1-22-69 M.H.

ORIGINAL FILED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6691
K-260 68-6691		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		ANTON J. KUCHAR		June 26, 1968 12:20 p.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 714 N. Curley St.		A. STATE Md., 21205		
		B. COUNTY 7-07		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 714 N. Curley St.		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/31/82
9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Kuchar		14. MOTHER'S MAIDEN NAME Marie Kolack		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-09-1802A		17. INFORMANT Antoinette Tuma Kuchar, wife, above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 23019 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior d. c.v. dis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellita 10 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION D	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 7-19-66 19 to 6-26-68 19, that (I) (we) lost sown the deceased olive on 6/26/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Benjamin B. Moses		23B. DATE SIGNED 6/28/68		23C. PHYSICIAN'S NAME (Type) Dr. Benjamin B. Moses
23D. ADDRESS 448 N. Luzerne Ave.		23E. DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/29/68	24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St.		

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6692</u>	
5-351		68-6692		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) STUMP, WILLIAM CLAUDE		2. DATE AND HOUR OF DEATH June 27, 1968 5:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 120 W. 25th St.			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-19	9. AGE (In years lost by day) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James A. Stump			
14. MOTHER'S MAIDEN NAME Eva Whittaker		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-1-43 to 11-7-45			
16. SOCIAL SECURITY NO. 226-12-1632		17. INFORMANT Records ADDRESS V. A. Hospital, Baltimore, Md. 21218			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) Disseminated Carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disseminated Carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 17, 1968 to June 27, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 27, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <i>C. R. Hamilton, Jr. M.D.</i> DEGREE				23B. DATE SIGNED June 28, 1968	
23C. PHYSICIAN'S NAME (Type) C. R. HAMILTON, JR., M.D. DEGREE		23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-28-68		24C. NAME of CEMETERY or CREMATORY Sifford Cemetery	
24D. LOCATION (City, town, or county) Parrott, Virginia		24E. STATE (State) Virginia			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR Wm. Johnson, 8521 Loch Raven Blvd. 21204	

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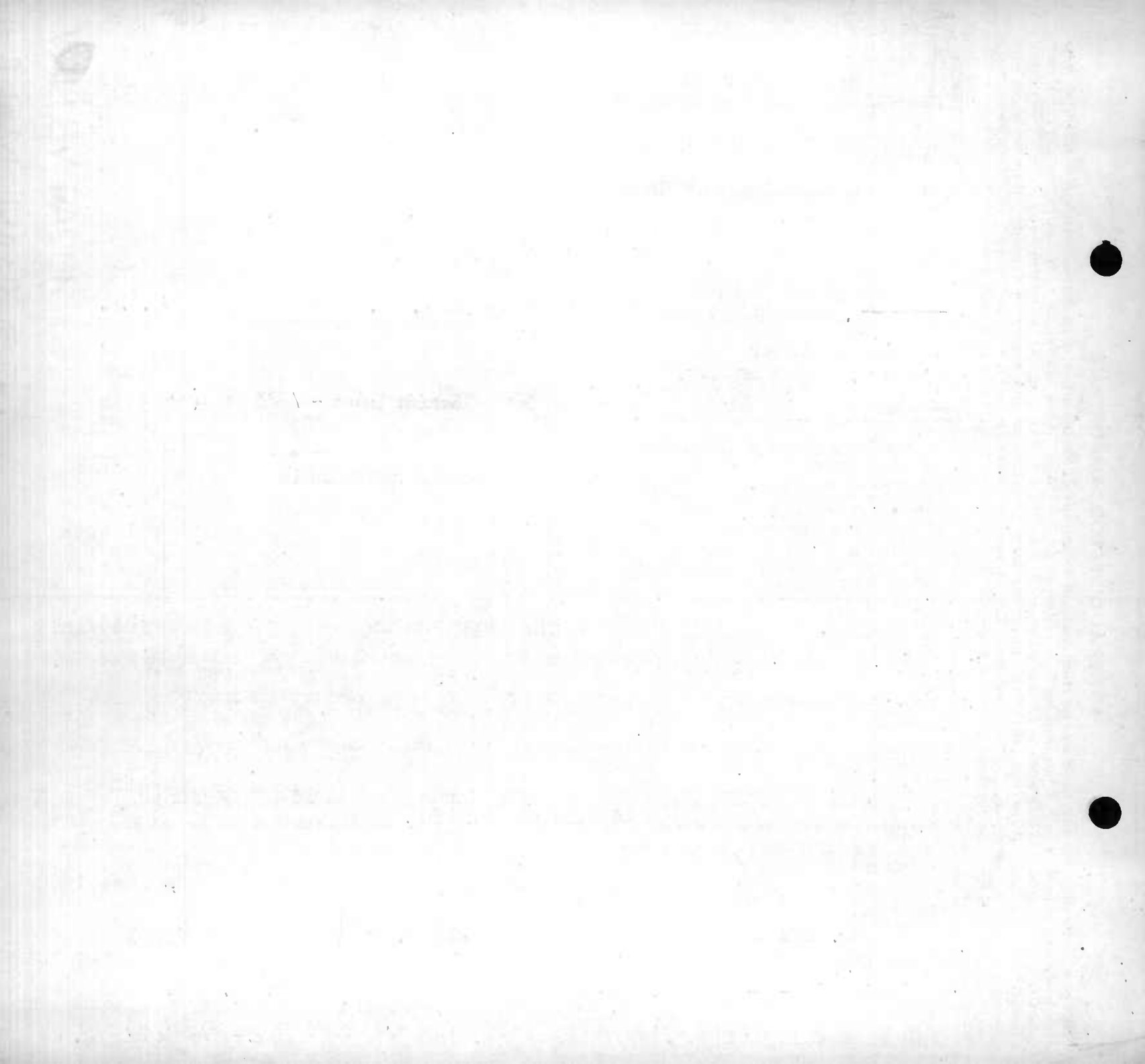
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

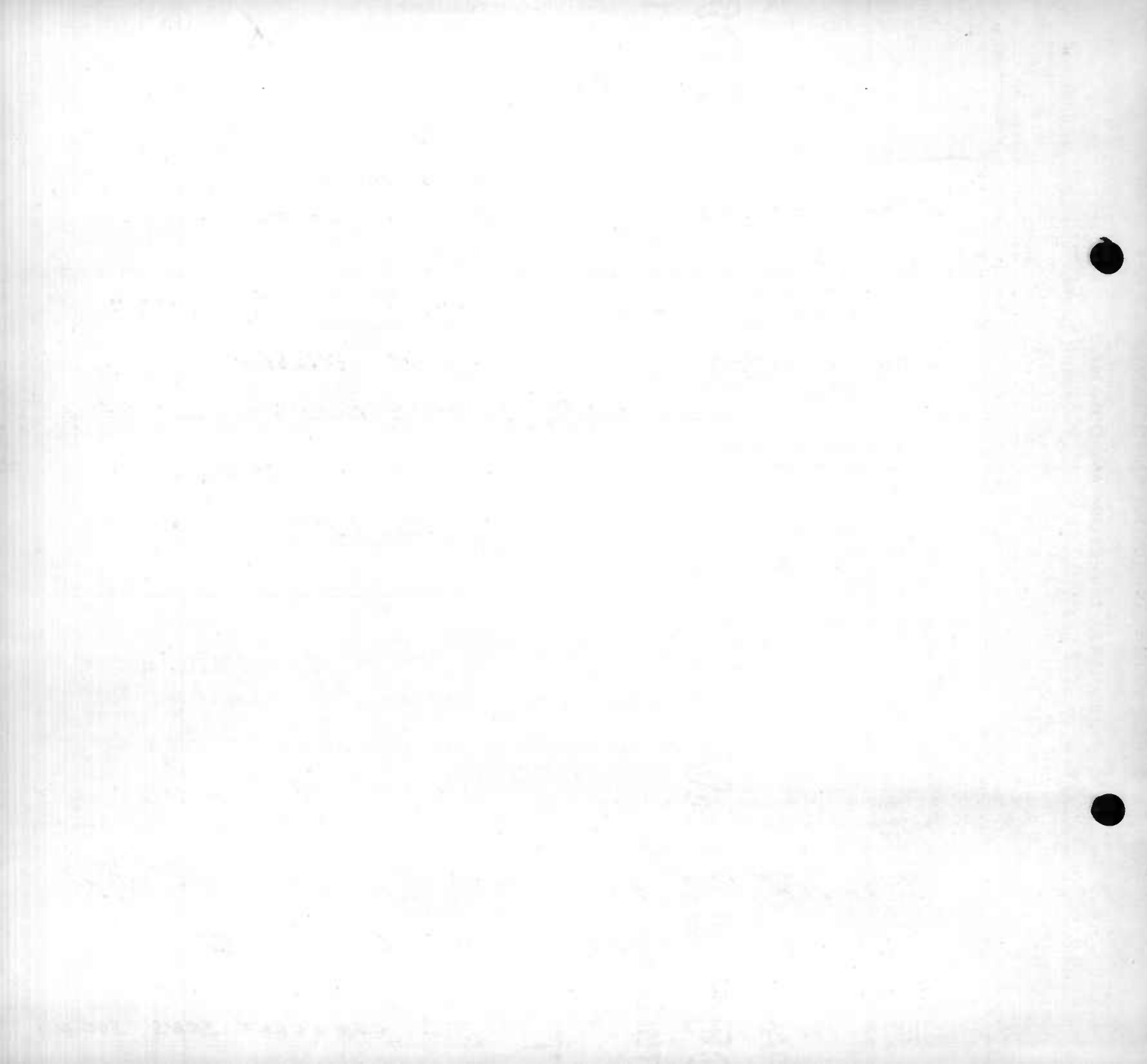
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6693</u>
5-656		68-6693		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frank Schirmer		
2. DATE AND HOUR OF DEATH June 24, 1968		10:45 p M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Fayette Convalescent Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto.		
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 18 Nov. 1876		9. AGE (In years last birthday) 91		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown Carpenter		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME August Schirmer		14. MOTHER'S MAIDEN NAME Mary Denz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 220-22-6828		17. INFORMANT Loretta Huber
18. 427.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHF		(B) DUE TO, OR AS A CONSEQUENCE OF:		1 week
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). BPH/ Hypotension		(C) _____		indefinite
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 25 March 1968 to 24 June 1968 , that (I) (we) lost saw the deceased alive on 24 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE J. Hulla		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 24 June 1968
23C. PHYSICIAN'S NAME (Type) J. Hulla		23D. ADDRESS 2214 E. Fayette Street 21231		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR John C. Mesler		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR John C. Mesler		25C. FUNERAL DIRECTOR ADDRESS Inc. - 415 Belair Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X 68-6694
E-640 68-6694 CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH JUNE 26, 1968		
1. NAME OF DECEASED (Type or Print) ALFARETTA N. EARLE		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS		
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHES		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN WHITE MARSH D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 122B VINCENT 53-00 BELTON RD
13. FATHER'S NAME JOHN LAUGHERY		14. MOTHER'S MAIDEN NAME MAUDE WILSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-07-138		17. INFORMANT MILTON R. EARLE ADDRESS ABOVE
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (B) AS CVD DUE TO, OR AS A CONSEQUENCE OF: (C)		
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 6/27 19 68 to 6/27 19 68, that (1) (we) last saw the deceased alive on 6/27 19 68 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Raymond N. Caplan				23B. DATE SIGNED 6/28/68
23C. PHYSICIAN'S NAME (Type) RAYMOND N. CAPLAN		23D. ADDRESS 1010 ST. PAUL ST		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY HOLLY HILL
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		
25B. NAME OF REGISTRAR R. E. J. J.		25C. FUNERAL DIRECTOR J. E. CONNELLY SONS ADDRESS 300 MACE		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6695
B-600		68- 6695 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
BOWER, MABEL GERTRUDE		6-25-68 8:00 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSP. WILKENS & CATON BALTIMORE, MD. 21229		A. STATE MD.		
		B. COUNTY RELAY		
		C. CITY OR TOWN RELAY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1731 MAGNOLIA AVENUE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-07-86	9. AGE (In years last birthday) 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) PENNA.
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME DANIEL W. ALOWAY		14. MOTHER'S MAIDEN NAME KATHARINE BERNHART		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-07-1193		17. INFORMANT ST. AGNES HOSP. RECORDS ROOM
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Cardiogenic shock</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>C. I. F.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Acute Myocardial Infarction</i>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 h -</i>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>		ASCD - CVA.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from JUNE 23 19 68 to JUNE 25 19 68, that (X) (we) last saw the deceased alive on JUNE 25 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.				
23A. SIGNATURE <i>Alexander Lucio Lopez</i>		23B. DATE SIGNED 06/25/68		
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA		23D. ADDRESS MD. St. Agnes Hospital.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/28/68	24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE	24D. LOCATION (City, town, or county) (State) HOWARD CO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968	25B. NAME OF REGISTRAR Robert E. Talbot	25C. FUNERAL DIRECTOR E. B. MacNabb		
		ADDRESS 301 Frederick Rd.		

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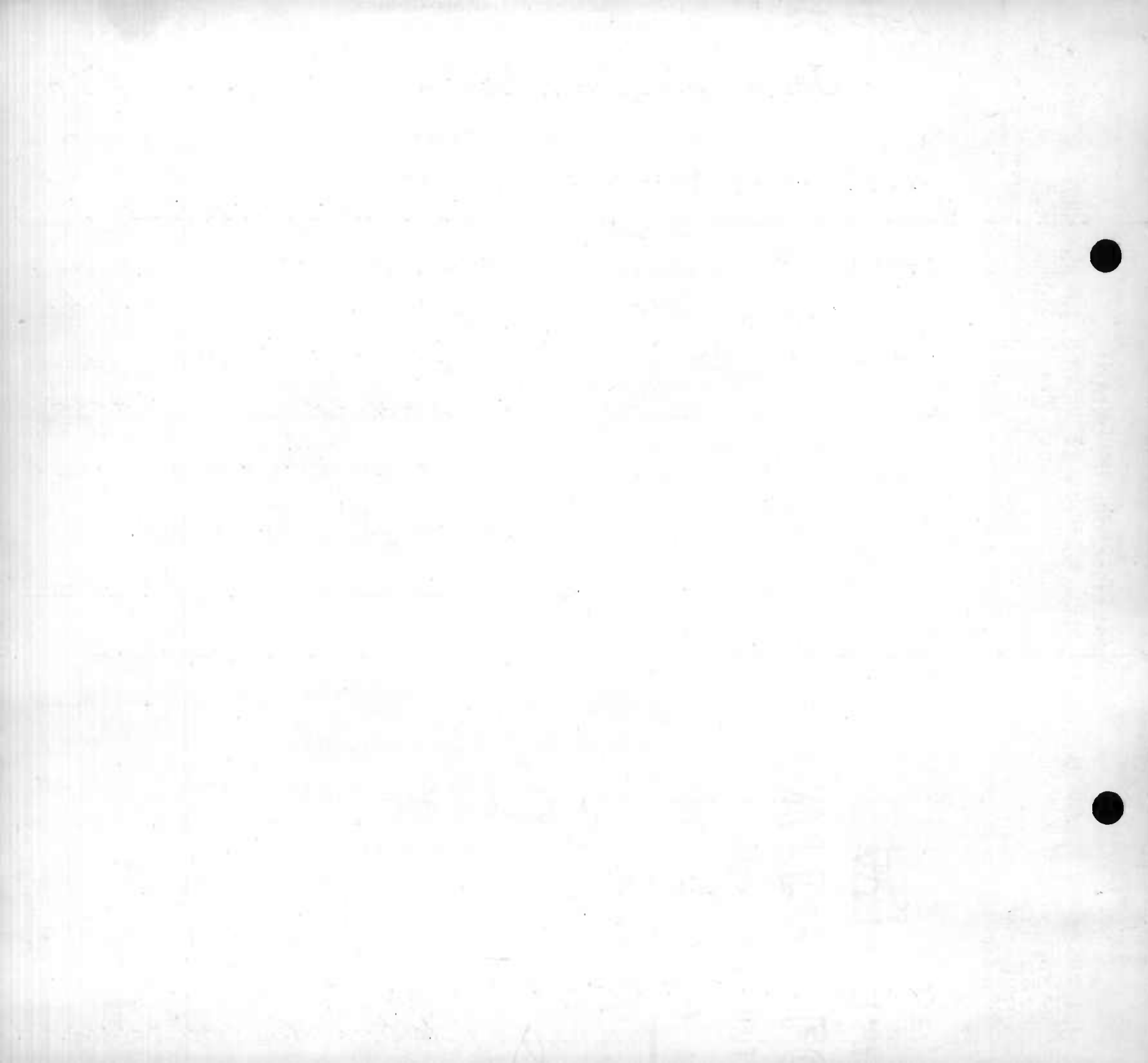
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FUNERAL DIRECTOR: IMPORTANT

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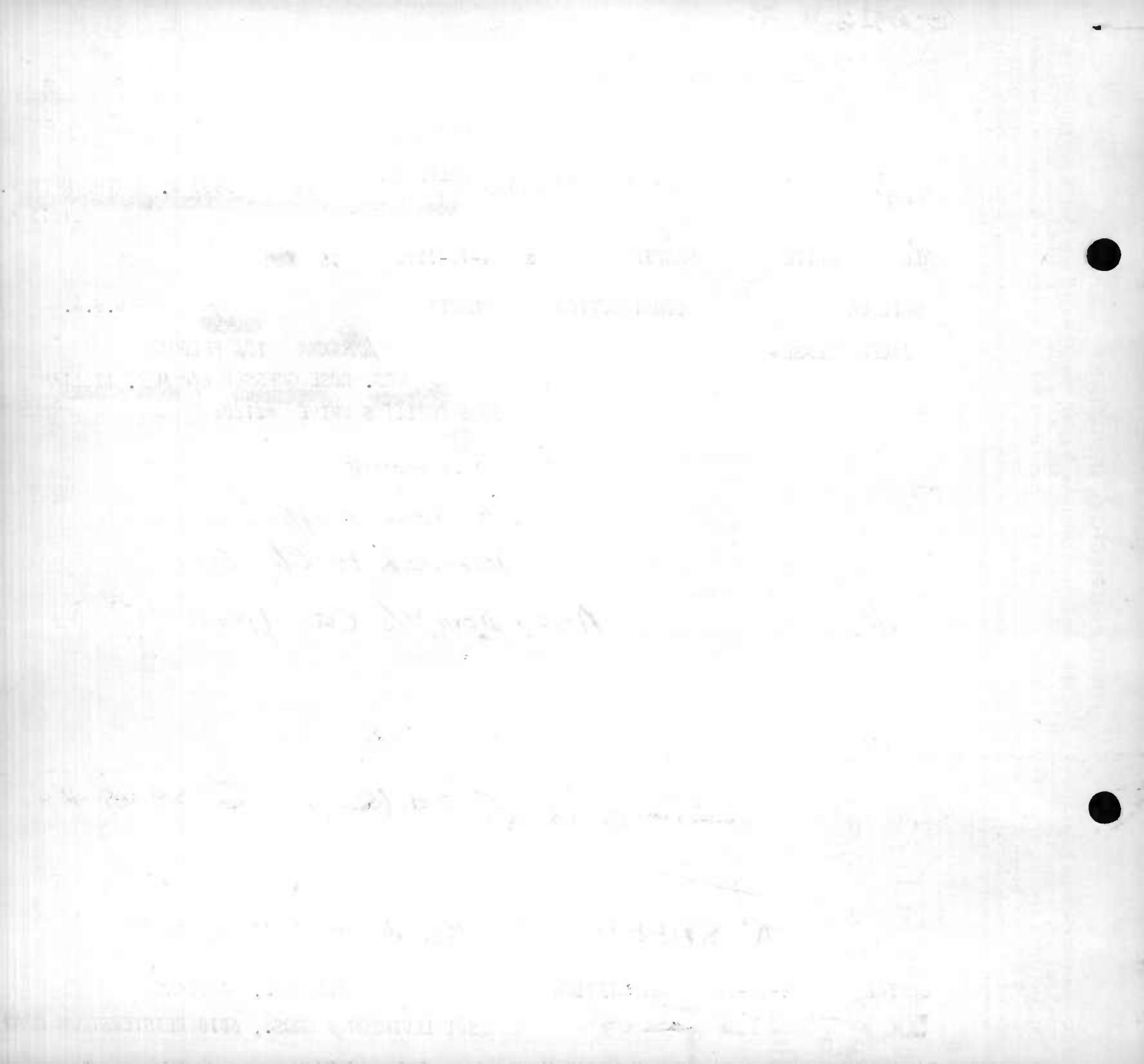
BALTIMORE CITY HEALTH DEPARTMENT										REG. NO. <u>68-6696</u>
10-236 BIRTH NO.		68-6696 CERTIFICATE OF DEATH				2. DATE AND HOUR OF DEATH <u>JUNE 28, 1968</u> <u>5:20 A. M.</u>				
1. NAME OF DECEASED (Type or Print) <u>JAMES MATTHEW NOCTOR</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> 8. COUNTY <u>24-02</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4313 VALLEYVIEW AVE.</u>						C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 14, 1901</u>		9. AGE (In years lost birthday) <u>66</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>CITY OF BALTO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES NOCTOR</u>						14. MOTHER'S MAIDEN NAME <u>MARY ANN BYRNE</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>				16. SOCIAL SECURITY NO. <u>218-22-5507</u>		17. INFORMANT <u>FAMILY</u>		ADDRESS <u>SAME</u>		
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary arteriosclerosis</u> (B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>		
19. <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>1968</u> to <u>28 June 1968</u> , that (I) (we) last saw the deceased alive on <u>10 Jan 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Harry J. Connolly</u>						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>28 June 1968</u>		
23C. PHYSICIAN'S NAME (Type) <u>Harry J. Connolly</u>						23D. ADDRESS <u>2800 York Road Balto MD 21204</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-1-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>				25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>J. Walter Conklin</u>				
ADDRESS <u>5444 BELAIR RD</u>										



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. 6-026</p> <p>68- 6697 CERTIFICATE OF DEATH</p> <p>Registered No. 68- 6697</p>			
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>GRESSER, DAVID</i></p>		<p>2. DATE AND HOUR OF DEATH <i>6-28-68</i> <i>8</i> <i>A</i> M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Balto, Maryland</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>27-195</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>3932 W. NORTHERN PKWY.</i></p>	
<p>5. SEX <i>MALE</i></p>	<p>6. RACE <i>WHITE</i></p>	<p>7. MARRIED, NEVER MARRIED <i>WIDOWED, DIVORCED (specify)</i> <i>MARRIED</i></p>	<p>8. DATE OF BIRTH <i>4-10-1890</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BUILDER</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <i>CONSTRUCTION</i></p>	<p>11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i></p>
<p>13. FATHER'S NAME <i>JACOB GRESSER</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>IDA FELDMAN</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <i>MRS. ROSE GRESSER c/o MRS. WILLIAM</i></p>		<p>18. CAUSE OF DEATH <i>3505 PHILLIPS DRIVE #21208</i></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>274X 17-180X</i></p>		<p>INTERVAL BETWEEN ONSET AND DEATH <i>Pneumonia</i></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Ch. Renal insufficiency possibly</i></p>		<p>(B) DUE TO <i>Secondary to Ch. Gout</i></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>288X II</i></p>		<p>(C) DUE TO <i>Ascaridosis, Hb Ca - prostatic</i></p>	
<p>19A. DATE OF OPERATION <i>0</i></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>6-24-68</i> 19 to <i>6-28-68</i> 19 that (I) (we) last saw the deceased alive on <i>6-28-68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>[Signature]</i></p>		<p>23B. DATE SIGNED <i>6-28-68</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>A. SAEED</i></p>		<p>23D. ADDRESS <i>Sinai Hospital of Balto. MD</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i></p>	<p>24B. DATE <i>6-28-68</i></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <i>BETH TFILOH</i></p>	<p>24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i></p>	<p>25B. NAME OF REGISTRAR <i>[Signature]</i></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6698</u>
5-536 68-6698		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <u>EDWARD J. SNYDER</u>		2. DATE AND HOUR OF DEATH <u>6.30.68</u> <u>4.40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> 8. COUNTY <u>ALL</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u>		C. CITY OR TOWN <u>Severn</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>Route 2 Box 4 52-00</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9.16.1909</u>	9. AGE (In years lost birthday) <u>58</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penn</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>170-18-3834</u>		17. INFORMANT <u>Mrs. Ivis Snyder Rt 2-Box 4 Severn Md</u>
18. <u>15-7-9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pneumonia</u> <u>Leucemia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5.24.68</u> to <u>6.30.68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>E. Rafael</u>		23B. DATE SIGNED <u>6.30.68</u>		23C. PHYSICIAN'S NAME (Type) <u>E. RAFAEL</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>BLAIRSVILLE</u>
24D. LOCATION <u>BLAIRSVILLE PENN A</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		
25B. NAME OF REGISTRAR <u>E. J. ...</u>		25C. FUNERAL DIRECTOR <u>4101 Edmondson Ave</u>		

Butcher Hospital
1000 10th St
x

Butcher Hospital
1000 10th St
x

Butcher Hospital
1000 10th St
x

F. 1907-1908
Butcher Hospital

Butcher Hospital
1000 10th St
x

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6699	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Mrs. MARY NAWROCKI</i>		2. DATE AND HOUR OF DEATH <i>6/28/68 8-15 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>35 Church Home & Hospital Fayette & Broadway Baltimore, Md. 21231</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore, Md.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1601 Pumphrey Street</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-8-83</i>	9. AGE (in years last birthday) <i>84</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>					
13. FATHER'S NAME <i>Rosimir Jagurak</i>		14. MOTHER'S MAIDEN NAME <i>Mary Noyak</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-05-4289</i>		17. INFORMANT (Husband) <i>Balto. ADDRESS Md.</i> <i>Michael Nawrocki Sr. 1601 Pumphrey St.</i>	
CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Pulmonary Embolism ?</i> DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart disease DUE TO, OR AS A CONSEQUENCE OF: (C) Peptic Esophagitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Few Minutes</i> <i>Several yrs</i> <i>Few Months</i>	
420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>4/23/68 & 5/14/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>leg ulcer & cystitis</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/8/1968</i> to <i>6/28/1968</i> that (I) (we) last saw the deceased alive on <i>6/28/68</i> and that in (my) (our) opinion death occurred on the date <i>6/28/68</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Krishna Reddy</i> DEGREE				23B. DATE SIGNED <i>6/28/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>KRISHNA REDDY</i> DEGREE				23D. ADDRESS <i>100N. Broadway, Balto. MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>	

11-8-83 84
Hood
Mary Hood

Bank of America
1001 Broadway
New York, N.Y.

W
H. W. Hood
H. W. Hood

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6700	
<div style="display: flex; justify-content: space-between;"> B-622 68-6700 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) ELLEN ALFREDA BURGESS </div> <div> 2. DATE AND HOUR OF DEATH June 27, 1968 11:20 A.M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY _____ C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2805 AILSA AVENUE		
5. SEX Female 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	6. RACE White 10B. KIND OF BUSINESS OR INDUSTRY _____	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-02-92	9. AGE (In years last birthday) 75 11. BIRTHPLACE (State or foreign country) VIRGINIA	If Under 1 Yr. Months: Days: Hours: Min. 12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME WILLIAM DODD			14. MOTHER'S MAIDEN NAME LOUISE BELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-6297 D 17. INFORMANT (Daughter) Balto. Md. 21214 Miss Alice Burgess, 2805 Ailsa Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of the liver. (A) GASTROINTESTINAL MALIGNANCY DUE TO, OR AS A CONSEQUENCE OF: (B) BRADYCARDIA DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 159X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Y.S		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from June 16, 1968 to June 27, 1968 , that (I) (we) lost saw the deceased alive on June 27, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> 23C. PHYSICIAN'S NAME (Type) MIGUEL SANCHEZ-PALACIOS			23B. DATE SIGNED June 27, 1968 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/1/68 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		
24D. LOCATION (City, town, or county) (State) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968 25B. NAME OF REGISTRAR Robert E. Feltz, MD		
25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			ADDRESS _____		

WILLIAM 3022

Union Memorial Hospital
GALT WORE
2802 ALMA AVENUE
X

F W X
13-03-95 72

Virginia
Levise Bell
WILLIAM 3022

GASTROINTESTINAL MANAGER

Yes

WILLIAM 3022
X
June 27, 1988
June 27, 1988
June 27, 1988
WILLIAM 3022
WILLIAM 3022
WILLIAM 3022

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 6701	
0-164 68- 6701				REG. NO. 68- 6701	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles H. Oberlander		6-26-1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
90 Gould Nursing Home			Md. Baltimore		
			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX 6. RACE			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		
Male Cau.			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
Box maker					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown Oberlander			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			215-03-0720		Mr William F. Oberlander 114 Raspe Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
420.11 II			Chronic Chemitz		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 20 19 68 to June 26 19 68, that (I) (we) last saw the deceased alive on June 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
V. SADARA NANDA MD				June 27-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				6801 Belair Rd Balto 6 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6-27-1968		Parkwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 1 1968		Robert E. Fairbanks		21236 ADDRESS	
				Massahn Funeral Home 7401 Belair Road	

that County Decisions

Administrative Decisions

County Decisions

County Decisions

County Decisions

County Decisions

County Decisions

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">S-530</div>		<div style="font-size: 1.5em; font-weight: bold;">68- 6702</div>		<div style="font-size: 1.5em; font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div>		<div style="font-size: 1.5em; font-weight: bold;">REG. NO. 68- 6702</div>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Smith, Frederica, A.</i>		2. DATE AND HOUR OF DEATH <i>6/25/68 11⁰⁰ P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>413 JOPLIN STREET #21224</i>			
5. SEX <i>Female</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/26/93</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>			
13. FATHER'S NAME <i>WINKLER HERMAN</i>		14. MOTHER'S MAIDEN NAME <i>ELLIE SPROUL</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-56-205</i>	
17. INFORMANT <i>JULIA WIATR</i>		ADDRESS <i>413 JOPLIN ST. BALTO., 21224, MD.</i>		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>250.9 I</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerosis</i>		<i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Diabetes mellitus</i>		<i>several yrs</i>		<i>several yrs</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>260X II</i>		<i>Long leg amputation</i>		<i>several yrs</i>		<i>several yrs</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11-16-1965</i> to <i>6-25-1968</i> , that (I) (we) lost saw the deceased alive on <i>6-28-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Ellsworth Cook</i>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-26-68</i>			
23C. PHYSICIAN'S NAME (Type) <i>E. ELLSWORTH COOK</i>		23D. ADDRESS <i>2431 Maryland Ave.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6-29-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>HOLY REDEEMER CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>4430 BELAIR RD, BALTO., MD.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Charles A. Gile</i>		ADDRESS <i>901 S. CONKLING ST. BALTO., 21224, MD.</i>		25D. DATE <i>6-26-68</i>			

BURIAL 4-29-48 HOLY REDEMPTION CH. 4430 BELAIR RD. BALTO., MD.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Benton, Matthew</u>		2. DATE AND HOUR OF DEATH <u>6/26/68</u> <u>3:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Maryland #21224</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3608 Manchester Avenue #21215</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/04</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis Kaplometz</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Goldstein</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>111-03-1955A</u>		17. INFORMANT <u>BCH: Records, 4940 Eastern Ave., Balto., Md.</u>	
18. <u>590.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Gram negative sepsis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cystitis, pyelonephritis</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <u>600.0 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<u>Decubiti, cerebral atrophy, Parkinsonism</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. ALNO? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>6/21</u> 19 <u>68</u> to <u>6/26</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6/26/68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Zachary Grossman M.D.</u> DEGREE		23B. DATE SIGNED <u>6/26/68</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. ZACHARY GROSSMAN</u>	
23D. ADDRESS <u>BCH: 4940 Eastern Ave., Balto., Md. #21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/27/68</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Cherry Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Randallstown Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>	
25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son Inc 9410 Reservoir Rd</u>		ADDRESS	

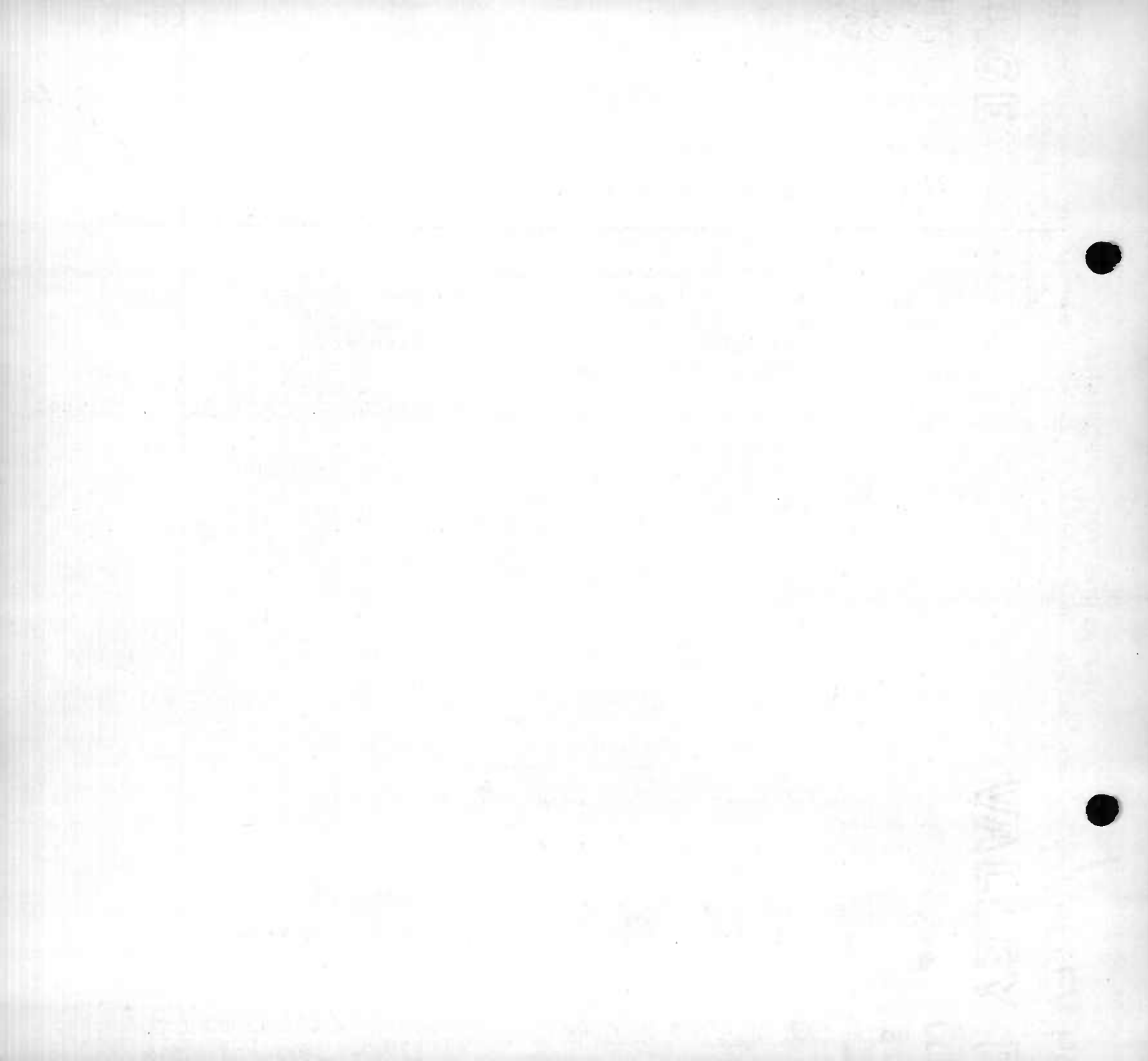
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

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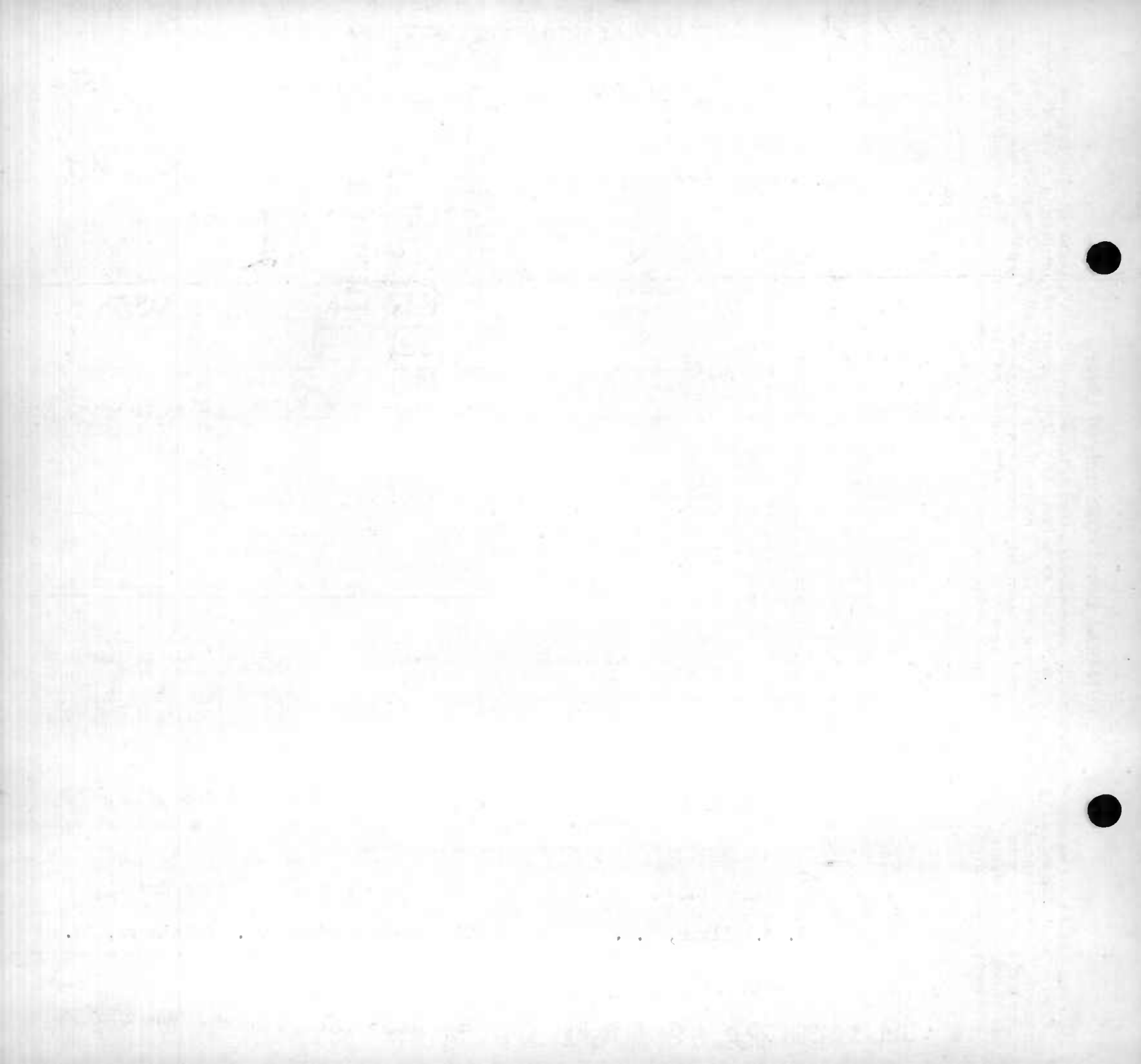
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6704
5-530		68- 6704 CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN PHILIP SMITH		
2. DATE AND HOUR OF DEATH JUNE 27, 1968		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 00 515 North Ellwood Avenue		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male		6. RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 17, 1884		
9. AGE (In years last birthday) 84		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Glasgow Scotland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Daniel Smith		
14. MOTHER'S MAIDEN NAME Margaret		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lillian J. Smith 515 N. Ellwood		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto Company 21. INTERMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto accident 22. UNDERLYING CAUSE DUE TO, OR AS A CONSEQUENCE OF: Auto accident		
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. DATE OF INJURY (Month) (Day) (Year) (Hour) 19D. TIME OF INJURY (APPROX.) 19E. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) 19F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 19G. HOW DID INJURY OCCUR? 19H. I certify that (I) (this hospital) attended the deceased from June 15, 1968 to June 27, 1968 , that (I) (we) last saw the deceased alive on June 26, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 15, 1968 to June 27, 1968 , that (I) (we) last saw the deceased alive on June 26, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23. DATE SIGNED 6/28/68		
23A. SIGNATURE William G. Geyer		23B. DATE SIGNED 6/28/68		
23C. PHYSICIAN'S NAME (Type) William G. Geyer		23D. ADDRESS 156 North Milton Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. (State)		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.
25D. ADDRESS Baltimore Maryland 21213		25E. (State)		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

68-6705 BALTIMORE CITY HEALTH DEPARTMENT REG. NO.		68-6705 CERTIFICATE OF DEATH	
BIRTH NO. L-132		2. DATE AND HOUR OF DEATH JUNE 26, 1968 5 A M.	
1. NAME OF DECEASED (Type or Print) GUSSIE LUBITCH		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2626 ROCKWOOD AVE		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME JERRY		14. MOTHER'S MAIDEN NAME YETTA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS JEANNETTE KATZ		ADDRESS 2626 ROCKWOOD AVE	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary Edema (B) arteriosclerotic heart - vascular disease (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/6 1935 to 6/26 / 68 19, that (I) (we) lost saw the deceased alive on 6/26/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. A. Silver		23B. DATE SIGNED 6/27/68	
23C. PHYSICIAN'S NAME (Type) A. A. Silver, M.D.		23D. ADDRESS 6210 Parks Heights Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68	
24C. NAME OF CEMETERY or CREMATORY VESHAER		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc		ADDRESS 9610 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

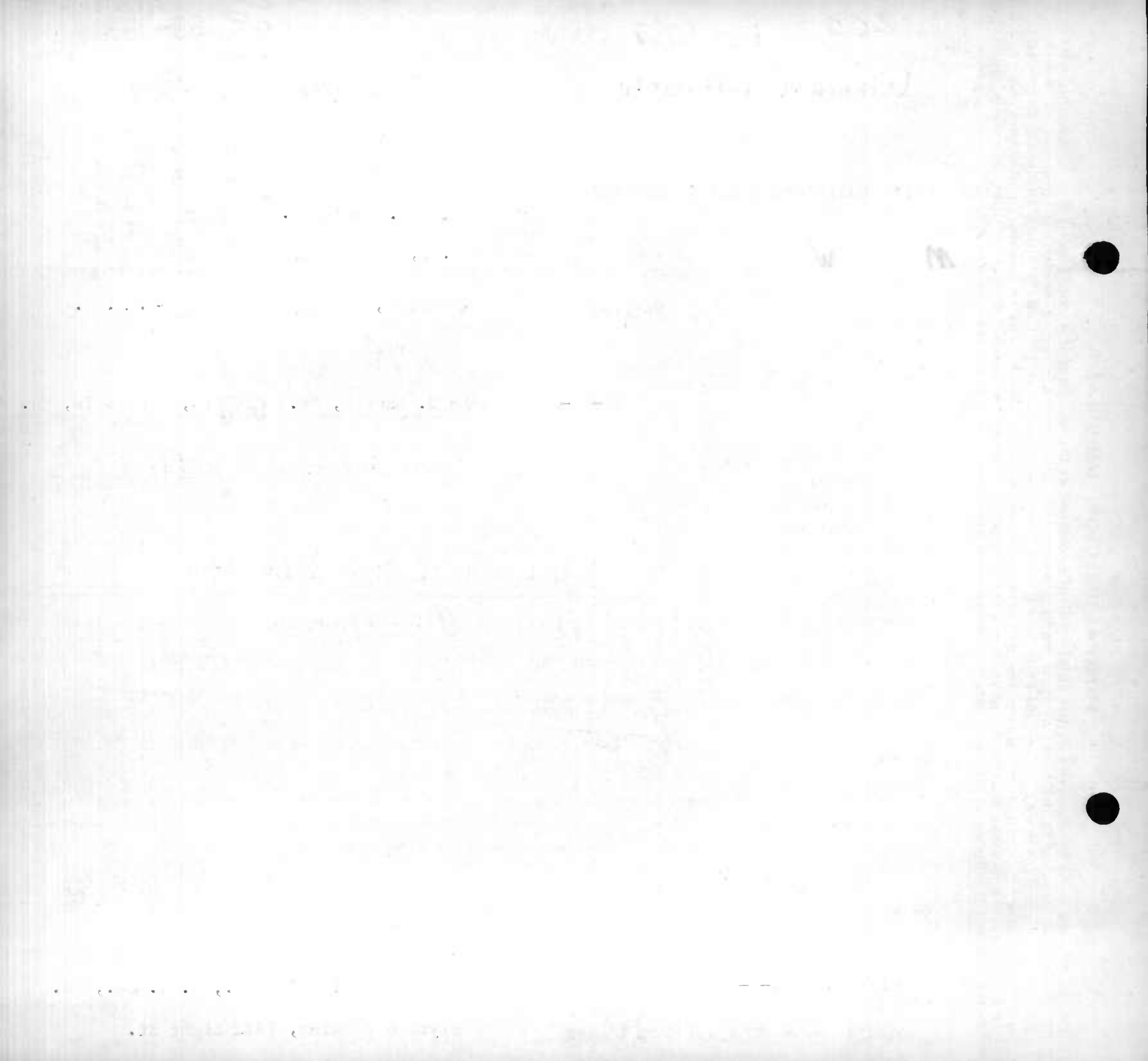
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6706	
<p>W-623 68- 6706 CERTIFICATE OF DEATH</p>					
BIRTH NO. 68-10544		1. NAME OF DECEASED (Type or Print) WRIGHT Baby Girl (Jovita)		2. DATE AND HOUR OF DEATH June 28 - 68 7:35 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTO, Md 21201		A. STATE MARYLAND	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 136-D Southridge Drive			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-68	9. AGE (In years last birthday) 17	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA - Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Wright		14. MOTHER'S MAIDEN NAME Patricia Myers	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James H. Wright	
18. 750.21		CAUSE OF DEATH		ADDRESS Southridge Pk. 21061	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Bacterial pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Congenital malformation			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Tracheo-esophageal fistula			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 16-12-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. J. H. Gowman				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. H. Gowman				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery Baltimore Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Philip E. Conner		25D. ADDRESS 1211 Chasara Ave			

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. L-200				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6707			
1. NAME OF DECEASED (Type or Print) William K. Lausch				2. DATE AND HOUR OF DEATH 6/30/68 3³³pm				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE Maryland			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 228 E. Cross St.							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				11. BIRTHPLACE (State or foreign country) Oldenberg, Germany				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Marie							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give wor or dotes of service) No				16. SOCIAL SECURITY NO. 215-10-2293				17. INFORMANT John J. Lausch, Rt.3 Box 410, Annapolis, Md.			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD							
				(B) DUE TO, OR AS A CONSEQUENCE OF: Thrombosis @ Midd. Cerebral Artery							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Pulm. Bronchopneumonia											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost saw the deceased olive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Emale M. Wood, M.D.				23B. DATE SIGNED 6/30/68							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Hwy., A. A. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Flynn & Fleming, 1422 Light St.		ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6708	
<div style="display: flex; justify-content: space-between;"> W-436 68-6708 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Lila Walters		2. DATE AND HOUR OF DEATH 6-25-68 5:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Allegany			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSP BALTIMORE, MD		C. CITY OR TOWN Flintstone, MD		5. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/1/57	
9. SEX F		10. AGE (In years lost birthday) 11		11. BIRTHPLACE (State or foreign country) Cumberland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Walter		14. MOTHER'S MAIDEN NAME Kaefer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mother		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 273.01		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Cystic Fibrosis (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mos 11 yrs	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 289.3 II					
19A. DATE OF OPERATION 2 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-13-68 to 6-25-68 , that (I) (we) last saw the deceased alive on 6-25-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Myron J. Adams, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-25-68	
23C. PHYSICIAN'S NAME (Type) MYRON J. ADAMS M.D.		23D. ADDRESS JOHNS HOPKINS HOSP - Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/1968		24C. NAME of CEMETERY or CREMATORY Mt. Zion Cemetery	
24D. LOCATION (City, town, or county) Chaneysville, Penna.		24E. ADDRESS Charles E. Haffer, 230 Balto Ave. Cumberland			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Charles E. Haffer	

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JOHN HOSKINS HARRIS
BIRMINGHAM, ALA

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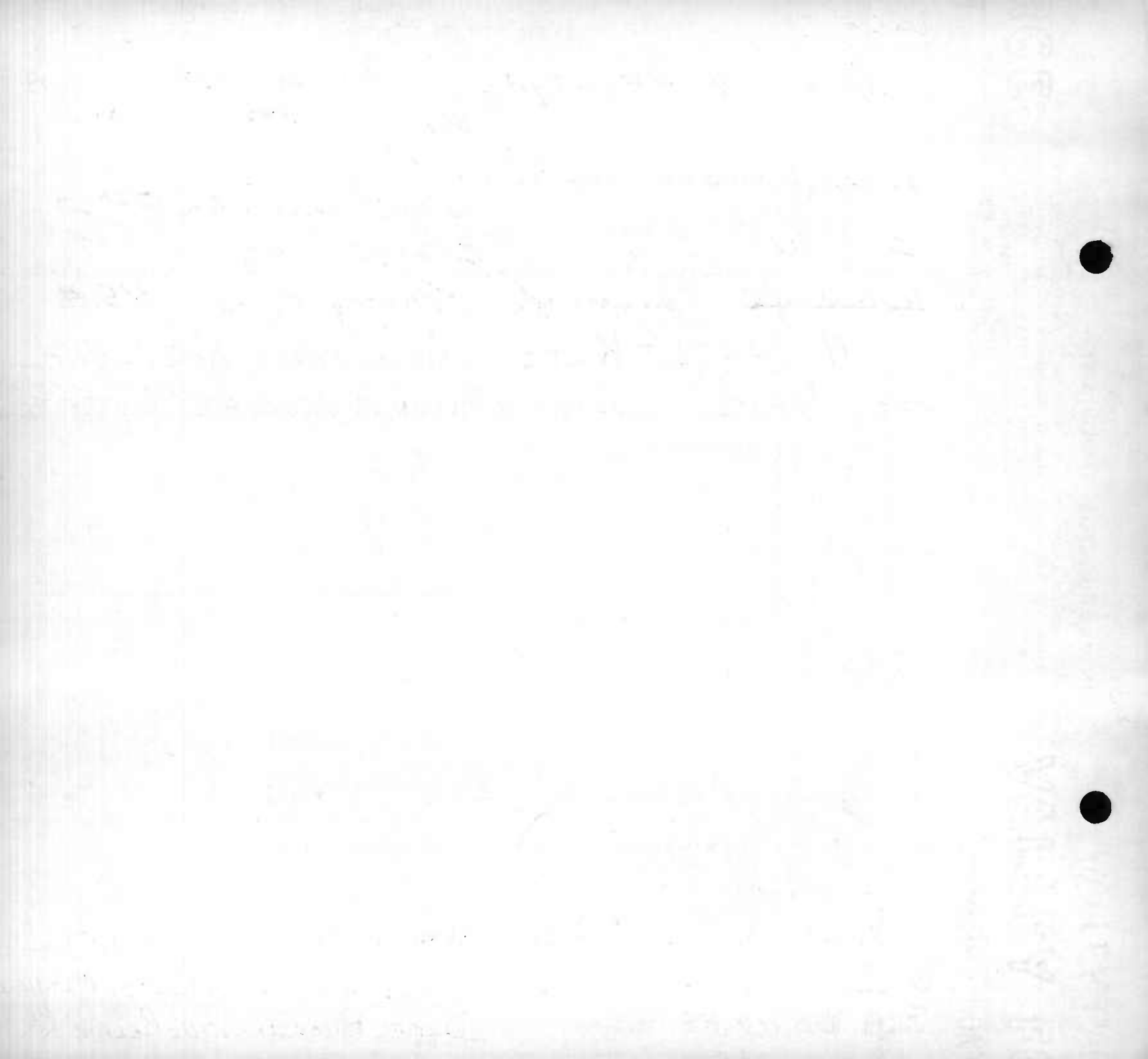
10-2-20

10-2-20

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6709</u>	
D-652 68- 6709		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>HELEN M. DERMOGA</u>		2. DATE AND HOUR OF DEATH <u>June 28, 1968</u> <u>1 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto. city</u> <u>26-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>6005 Moduth Ave</u>		<u>MARLWTH</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-95</u>	9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>MICHAEL - KUTZ</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE KORYLSKA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 033930</u>		17. INFORMANT <u>MELVIN A. DERMOGA</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>MI</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Peripher & General atherosclerosis years</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u>					
19A. DATE OF OPERATION <u>16/27/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>AS advise Oly.</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Office</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>6-28-68</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-15-68</u> to <u>6-28-68</u> 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>6-28-68</u> 19 <u>68</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Frank J. Gilhen Jr.</u>				23B. DATE SIGNED <u>6-28-68</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK J. GILHEN Jr.</u>		23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>7-1-68</u>	24C. NAME OF CEMETERY or CREMATORY <u>PARKWOOD CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>TAYLOR AVE. BALTO. MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>DIPPEL BROS. INC. 7110 BELAIR RD.</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6710

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT SEIGALE

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

6

28

68

3:00 a. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

36

Franklin Square Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 28,

1968

3:00 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Colored

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

March 23, 1923

10. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1101 Harlem Ave.

11. BIRTHPLACE (State or foreign country)

St. Mary's Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Randolph Sigale

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hattie Burriel

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Edward Sigale 2410 Huron St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Craniocerebral Injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

?? Unk.

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unk?

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) June 27, 1968 ??22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Probable fell while drinking

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 28, 1968

24A. BURIAL CREMATION,
REMOVAL, (Specify)

Burial

24B. DATE

7/2/1968

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Balto. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1968

25B. NAME OF REGISTRAR

R. L. B. Jr.

25C. FUNERAL DIRECTOR

Williams Funeral Home 3197 Schrad St.

ADDRESS

1875

1875

March 1875

St. Mary's Co. Md. 1875

Laborer

No

Charles E. Sigle

John E. Sigle

Edward Sigle 2100 Harbor St.

WALTER BROWN

April

James M. Brown Co. Baltimore Md.

William Brown 2100 Harbor St.

1

D-600 68-6711 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6711 4

BIRTH NO. 68-10818

1. NAME OF DECEASED (Type or Print) (New born) DRY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 8, 1968 1:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 8, 1968 1:10 P.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years lost birthday) new born		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 1211 W. Lexington Street	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Precipitous Delivery (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/9/68			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE JUNE 1968	
24C. NAME OF CEMETERY or CREMATORY MORGLUE		24D. LOCATION (City, town, or county) (State) 700 FLEET ST.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR R. E. F. F.	
25C. FUNERAL DIRECTOR MORGLUE		ADDRESS	

VS 151-REV. 1/1/68

WALLACE GUY BODIN

5/14/1911

1

C-163 68-6712 BALTIMORE CITY HEALTH DEPARTMENT 68-6712

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

1. NAME OF DECEASED (Type or Print) BABY BOY CYFORD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> May 11, 1968 Hour 10:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year May 11, 1968 Hour 10:30 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday) NB	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 776.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Atelectasis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		DATE SIGNED 5/12/68	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 6-21-68	
24C. NAME OF CEMETERY or CREMATORY Medical Examiner Office		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Schuyler	
25C. FUNERAL DIRECTOR MORQUE		ADDRESS	

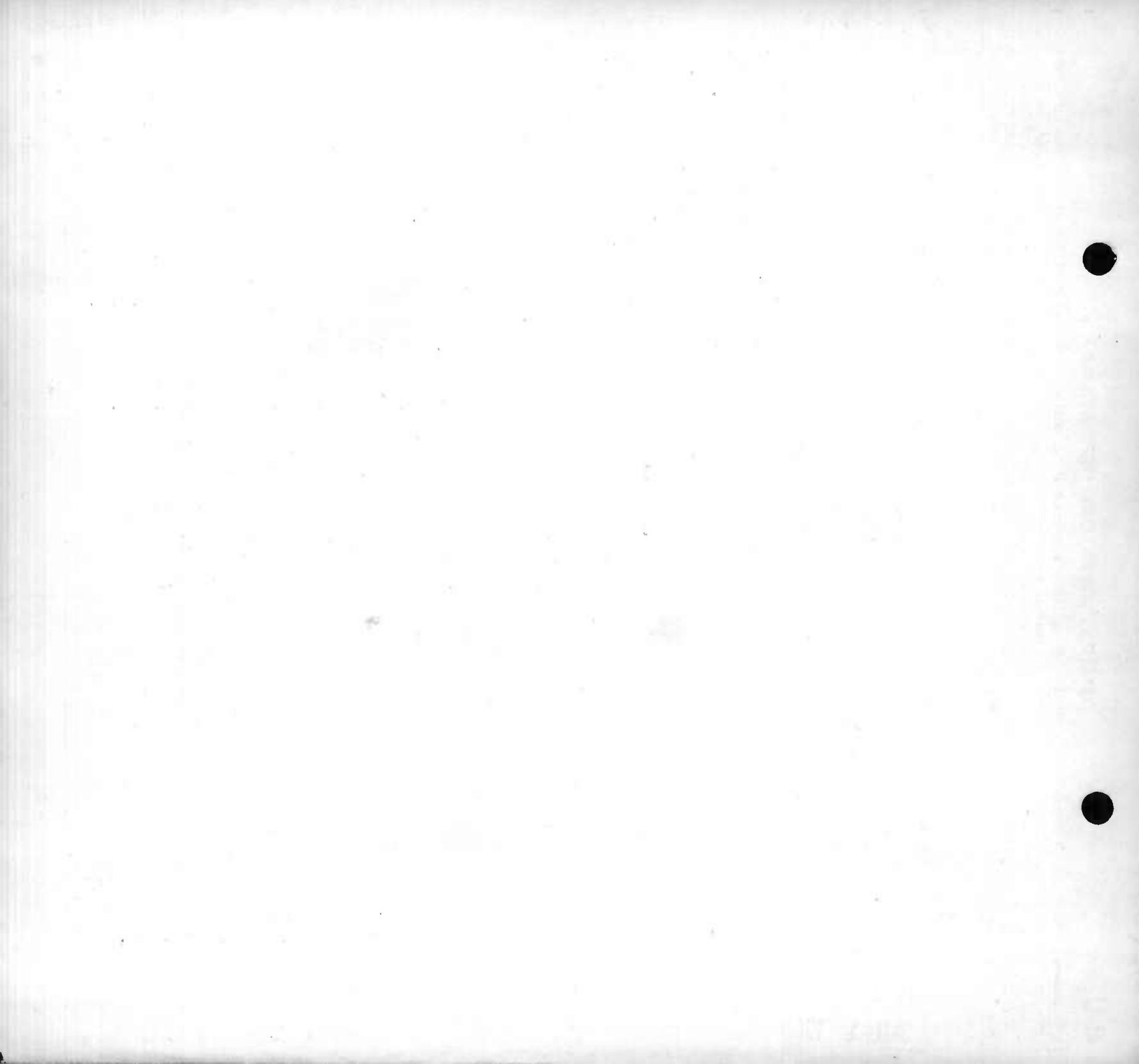
Order No.

WILLIAM B. ROSE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

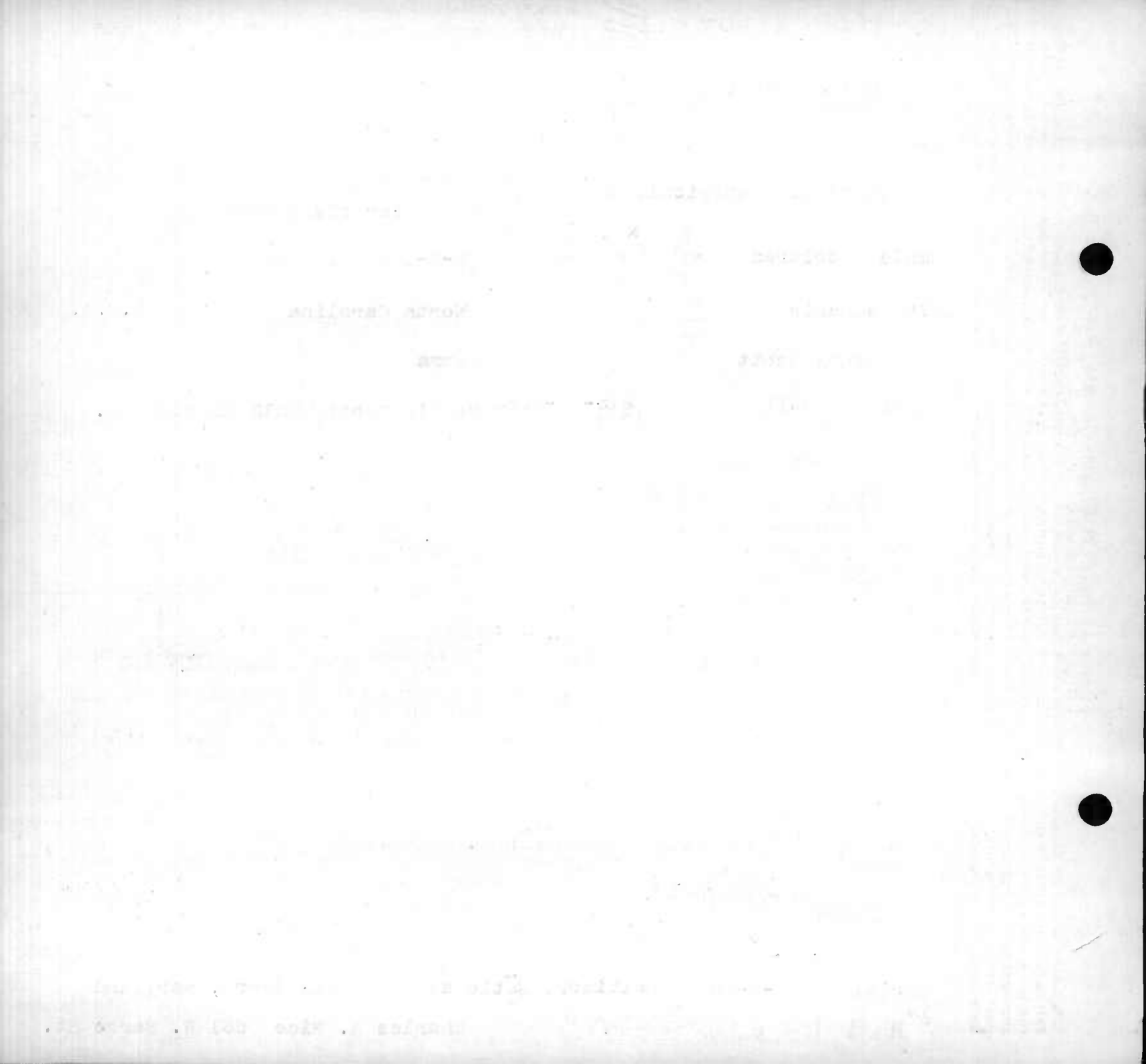
Baltimore City Health Department				REG. NO. 68- 6713	
D-243 68- 6713				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CLARA L. DESHIELDS		2. DATE AND HOUR OF DEATH 6/27/68 2 50 p M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 26 S. EXETER STREET 21202	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/98	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR DEAN		14. MOTHER'S MAIDEN NAME BARBARA WHITLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 4123 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPTICEMIA (B) 2 urinary Tract Infection, chronic, Renal Failure (C) Multiple CVA's 2 ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		422.1 II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 19 68 to 6/27 19 68, that (I) (we) last saw the deceased alive on 6/27 19 68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David E. MCBETH MD		23B. DATE SIGNED 6/27/68		23C. PHYSICIAN'S NAME (Type) DAVID E. MCBETH	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		23E. FUNERAL DIRECTOR 6 A7 Halstead 1206 W North Ave		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		24E. DATE REC'D BY HEALTH DEPT. JUL 1 1968		24F. NAME OF REGISTRAR Robert E. Fisher	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6714	
<div style="display: flex; justify-content: space-between;"> 5-300 68-6714 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bailey Scott		2. DATE AND HOUR OF DEATH 6/28/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2313 Norfolk Street		
5. SEX male	6. RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Henry Scott			14. MOTHER'S MAIDEN NAME Emma		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 215-05-8960		17. INFORMANT Mollie Scott 2313 Norfolk St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.91-250.9 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 1. AC MYOCARDIAL INFARCTION UNKNOWN (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2. ARTERIOSCLEROTIC CARDIOVASCULAR DIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ DIABETES MELLITUS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): 420.1 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
19A. DATE OF OPERATION 6/20/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/5/68 to 6/28/68 , that (I) (we) last saw the deceased alive on 6/5/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John S. Brannon				23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) JOHN S. BRANNON				23D. ADDRESS 922 S. SHARP ST., BALT., MD 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.			

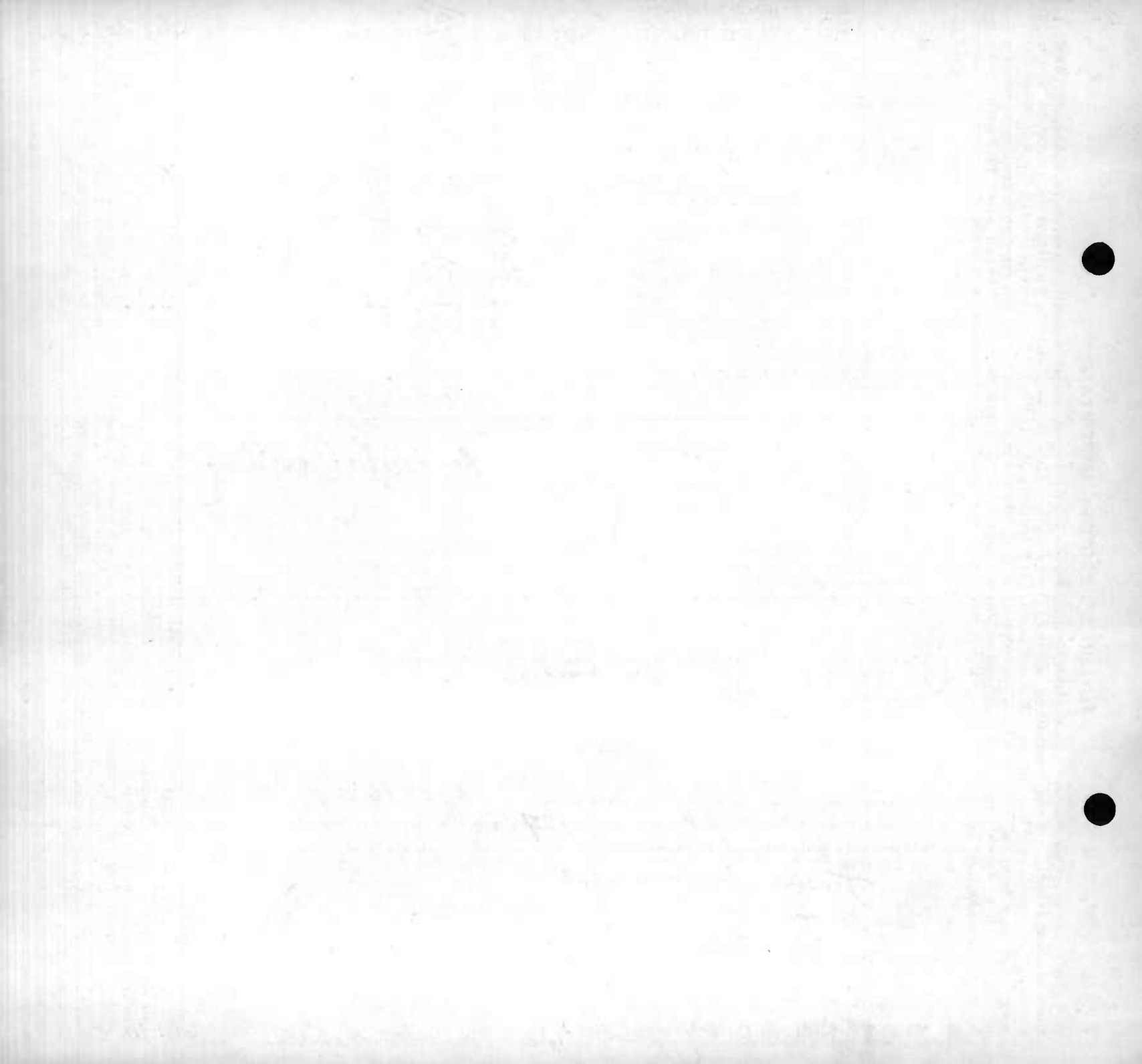


52-02-97 IT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-6715
BIRTH NO.				6-422 68-6715	
1. NAME OF DECEASED (Type or Print) <i>Blockes, Deborah</i>				2. DATE AND HOUR OF DEATH <i>6/27/68 9.30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS</i> ADDRESS OR LOCATION <i>4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i>				C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>861 BETHUNE ROAD</i>					
5. SEX <i>FEMALE</i>	6. RACE <i>NERGO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-7-54</i>	9. AGE (In years last birthday) <i>13</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>ANDERSON BEST</i>		14. MOTHER'S MAIDEN NAME <i>PEARL</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>BALTIMORE CITY HOSPITALS RECORDS 4940 EASTERN AVENUE #21224</i>	
18. <i>7359 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Ac. Cerebral swelling</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6/27/68 - 6/27/68</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>334X II</i>					
19A. DATE OF OPERATION <i>6/27/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Semicomscious</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/27/68</i> 19 to <i>6/27/68</i> 19, that (I) (we) last saw the deceased alive on <i>6/27/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jesada Nimmannitya</i> DEGREE				23B. DATE SIGNED <i>6/27/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Dr. JESADA MD</i> DEGREE				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-1-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles A. Rice 661 W. Bore St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO. 68-6716

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Carl O. Happel

2. DATE AND HOUR OF DEATH

6-30-68 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

718 E. 43rd St.

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9-4-11

9. AGE (In years lost birthday)

56

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland U.S.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Omar C. Happel

14. MOTHER'S MAIDEN NAME

Mary Owen

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-07-3507

17. INFORMANT

Eleanor F. Happel

ADDRESS

same

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

Acute Myocardial Infarction

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerotic Heart Disease

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

9 days

??

MEDICAL CERTIFICATION

420.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

—

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-21-1968 to 6-30-1968, that (I) (we) last saw the deceased alive on 6-30-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William L. Boddie

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6-30-68

23C. PHYSICIAN'S NAME (Type)

William L. Boddie

23D. ADDRESS

Maryland General Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/3/68

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION

Baltimore Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1968

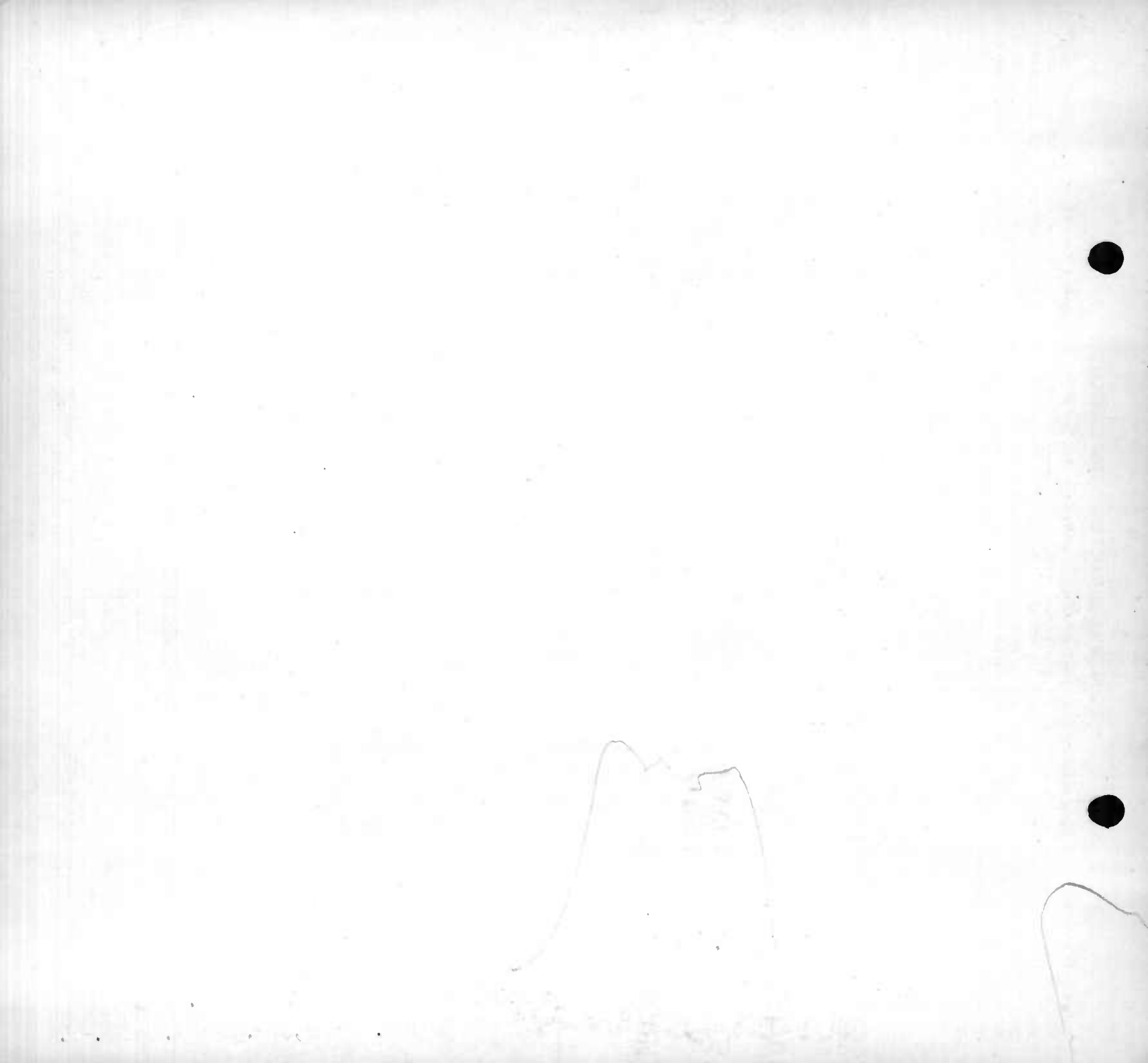
25B. NAME OF REGISTRAR

Robert E. Finkbeiner

25C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

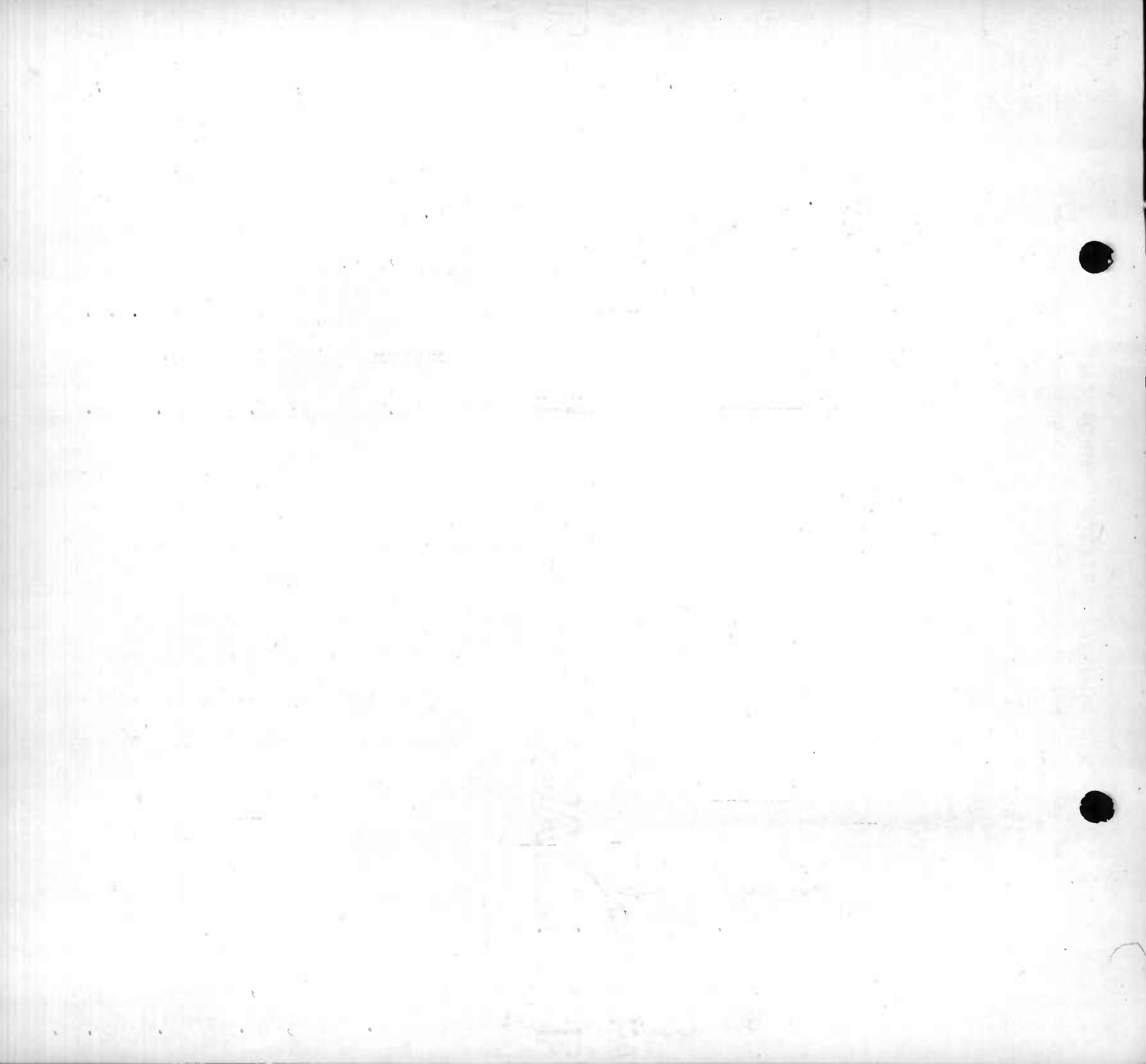
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6717	
BIRTH NO. 68- 6717		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) George L. Jones		2. DATE AND HOUR OF DEATH June 29, 1968 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 505 E. 43rd Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 505 E. 43rd Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1899	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Jones		14. MOTHER'S MAIDEN NAME unknown Elizabeth Howels	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-07-4511		17. INFORMANT ADDRESS Ethel E. Jones 505 E. 43rd St. Balto.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 15-IX I CAUSE OF DEATH Carcinoma of stomach with generalized metastasis 1 yr.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with generalized metastasis		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) -----	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 15-IX II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 67 to June 29, 19 68 , that (I) (we) last saw the deceased alive on June 24, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor		23B. DATE SIGNED July 1, 1968		23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.	
23D. ADDRESS 3902 Greenmount Avenue		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1, 1968		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto. St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

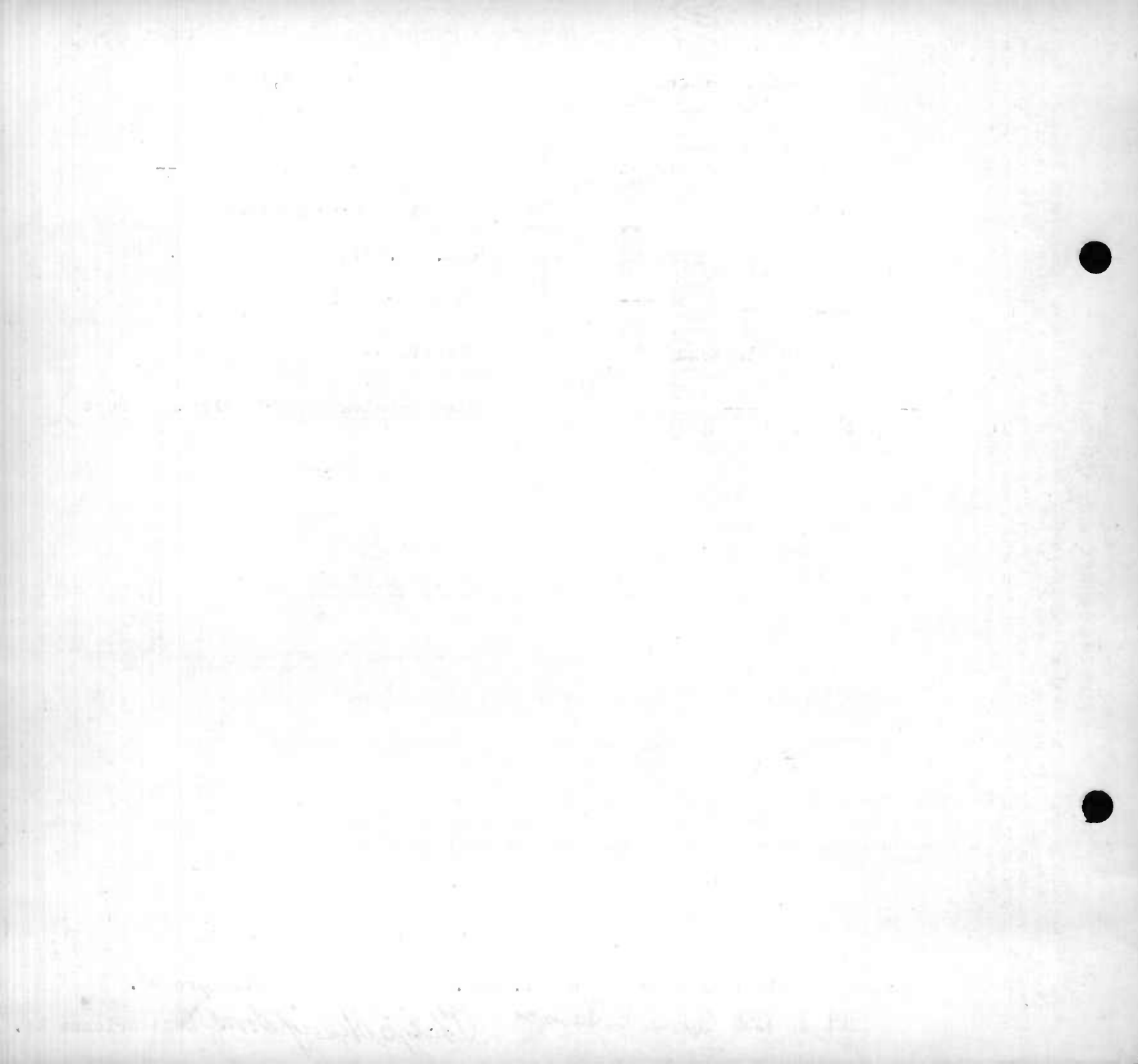
BIRTH NO.		68- 6718		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68- 6718	
1. NAME OF DECEASED (Type or Print) PAUL BRICHETTO				2. DATE AND HOUR OF DEATH 6/28/68 10-40P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 MARYLAND GENERAL HOSPITAL - BALTIMORE md 21201				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-01					
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 147 N. STREEPER ST.					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/93		9. AGE (In years lost birthday) 74		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul? BRICHETTO				14. MOTHER'S MAIDEN NAME unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI				16. SOCIAL SECURITY NO. 004-01-9659		17. INFORMANT Mrs Laura Zalecki		ADDRESS 8 Winona Ave Balto #22	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PULMONARY OEDEMA				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC C.V. DISEASE Years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 4 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PNEUMONITIS 2LL lung weeks				(B) DUE TO, OR AS A CONSEQUENCE OF: Vascular & Basilar Artery Stenosis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II									
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that my (this hospital) attended the deceased from 5/23/1968 to 6/28/1968 , that my (we) last saw the deceased alive on 6/28/1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. my (we) (did) (did not) view the body after death.									
23A. SIGNATURE Zaheer ud Din md						23B. DATE SIGNED 6/28/68			
23C. PHYSICIAN'S NAME (Type) ZAH-EER-UD-DIN						23D. ADDRESS 40 Maryland General Hospital Baltimore - md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6719				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6719				
1. NAME OF DECEASED (Type or Print) Josefa Jerabek						2. DATE AND HOUR OF DEATH June 27, 1968						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2130 Orleans Street						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 6-03						
5. SEX Female			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9th. 1874		9. AGE (In years last birthday) 83		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---						10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Thomas Planicka						14. MOTHER'S MAIDEN NAME Josefa --						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Frank Jerabek				ADDRESS 2030 Orleans Street		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. He RD Marfan's defect						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: He RD (B) DUE TO, OR AS A CONSEQUENCE OF: Marfan's defect (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d indif "				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 443X II												
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 1930 to 27 Jun 1968 , that (I) (we) lost saw the deceased alive on 27 Jun 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE Hulla						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 28 Jun 68				
23C. PHYSICIAN'S NAME (Type) Hulla						23D. ADDRESS 2214 E. Gay St. Balt Md 21231						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE July 1st/68		24C. NAME OF CEMETERY or CREMATORY Bohemian Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968				25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Philip H. Henry, Sons		ADDRESS 2024 Orleans St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6720	
1. NAME OF DECEASED (Type or Print) Eleanor M. BALLARD			2. DATE AND HOUR OF DEATH June 29, 1968 1:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 24-01.		
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore GENERAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 1455 HULL STREET 21230		
5. SEX FEMALE White	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-12-34	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WESTINGHOUSE			11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John F. Wilson			14. MOTHER'S MAIDEN NAME Margaret ESTELLE STAINES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-30-5485		17. INFORMANT Margaret Estelle Wilson ADDRESS 1455 Hull St.
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Overwhelming infection & anemia			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Ca of breast & osseous metastasis DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Ca of breast & generalized metastasis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 13, 1968 to JUNE 29, 1968 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JUNE 29, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard H. Reed MD				23B. DATE SIGNED JUNE 29, 1968	
23C. PHYSICIAN'S NAME (Type) Richard H. Reed				23D. ADDRESS SOUTH BALTIMORE GENERAL HOSPITAL 1213 LIGHT STREET BALTO. MD. 212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY Stone Chapel Cemetery Carroll, Maryland	
24D. LOCATION Carroll, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 11501 East Fort Avenue			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6721	
68- 6721					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bertorelli, Peter M.</i>		2. DATE AND HOUR OF DEATH <i>6-28-68</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balto. General Hosp.</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43</i>			E. STREET AND NUMBER <i>1306 Gough St.</i>		<i>3-02</i>
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-29-06</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>City of Baltimore</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Joseph Bertorelli</i>		
14. MOTHER'S MAIDEN NAME <i>Mary Morris</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>213-12-4856</i>			17. INFORMANT ADDRESS <i>Hospital Records - Italy</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>410.9 I</i>			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <i>Myocardial Infarction, Probable days</i>		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Atherosclerotic CVD</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>420.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/24/68</i> 19 to <i>6/28</i> 19 <i>68</i> . that (I) (we) last saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rifat Abousy</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Rifat Abousy</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 2-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>4430 Belair Rd. Balt. Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Frank Dellanoce 322 S. High St -</i>			

Confidential

213-12-1070

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M 200

68- 6722

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6722

BIRTH NO. 68-09016

REG. NO.

1. NAME OF DECEASED (Type or Print) LINDA M. MCCOY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 26 68 12:40 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 532 W. Lanvale St.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26, 1968 12:40 a.m.	
6. SEX Female		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-02	
9. DATE OF BIRTH May 19, 1968		10. AGE (In years last birthday) 1 Months 1 Days 1 Hours 1 Min.	
11. BIRTH PLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? John Daniels	
13. FATHER'S NAME John Daniels		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Frances McCoy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Frances McCoy	
19. 484 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Interstitital pneumonitis (SDII)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION 3-23-68		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED June 26, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 28, 1968	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2222 W. North Ave.	

Handwritten text at the top of the page, mostly illegible due to fading.

John Brown
Channing Dyer
Miss Anne Dyer

My dear
Friend

Received of you the sum of \$10.00

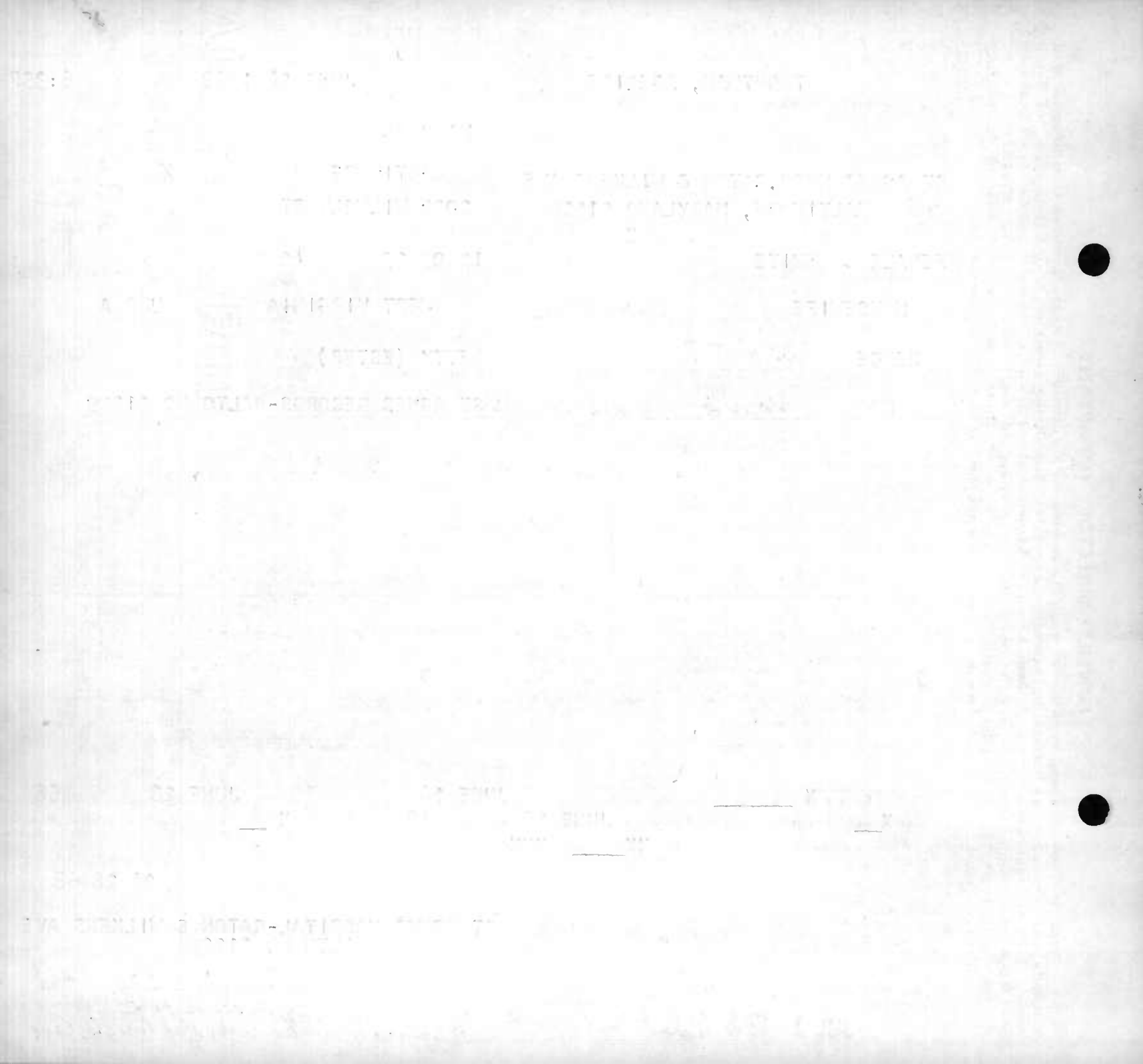
for the purchase of the
book of the same title
as above mentioned

Yours very truly
Wm. Lloyd Garrison

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6723
68- 6723		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		TROUTMAN, ADELENE		JUNE 28 1968 6:35P
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSP. CATON & WILKENS AVE 40 BALTIMORE, MARYLAND 21229		A. STATE MARYLAND B. COUNTY 2003 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2007 WILHELM ST		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 09 25	9. AGE (In years lost birthday) 42
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME HENCE WHITT		
14. MOTHER'S MAIDEN NAME BETTY (ESTEP)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		
16. SOCIAL SECURITY NO. 213-26-3888		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 600.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION June 67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Kidney Biopsy - see "C" 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days - (A) IMMEDIATE CAUSE Chronic Bronch - DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic Uremia DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Prolonged Uremia Secondary Chronic Congestive H.F.		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 16 1968 to JUNE 28 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 28 1968 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Alejandro Mejia MD		23B. DATE SIGNED 06 28 68		23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA MD
23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 7-1-68		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty. Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTAR Robert E. Feltner		25C. FUNERAL DIRECTOR GEO. L. SCHWAB FUNERAL HOME Francis W. Miller 2101 Frederick Ave



1
B-400

68- 6724

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6724
REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERTHA BAILEY				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> June 1968 M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1710 Presbury Street				3. DATE PRONOUNCED DEAD Month Day Year Hour June 27, 1968 1:15 P.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1502							
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10/4/1900		10. AGE (In years lost birthday) 68		E. STREET AND NUMBER 1710 Presbury Street			
11. BIRTHPLACE (State or foreign country) Eastern, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Baptist			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY Domestic Serv.		15. MOTHER'S MAIDEN NAME Mannie DeShields			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 217-20-6358		18. INFORMANT ADDRESS Loretta Brown, 1012 Gilmore St.			
19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 27, 1968							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Balto, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOME, INC. 1701 Laurens Street			

James F. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6725

BIRTH NO. 68- 6725		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) Maggie Williams		2. DATE AND HOUR OF DEATH June 28, 1968 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-05	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2531 Calverton Heights Baltimore, Maryland		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 2531 Calverton Heights	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (State or foreign country) South Boston, Va.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Andrew Crawley		14. MOTHER'S MAIDEN NAME Pattie Crawley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N.A.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gladys Roberts		ADDRESS 2531 Calverton	
18. 4432 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) HA.S.C.V.D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Senile degeneration		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Senile degeneration (C) Senile degeneration	
19. DATE OF OPERATION 443X II		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from 2-16-1968 to 6-28-1968 , that (I) (we) last saw the deceased alive on 2-21-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE C.R. Campbell, M.D.		23B. DATE SIGNED 7-1-68	
23C. PHYSICIAN'S NAME (Type) C.R. Campbell, M.D.		23D. ADDRESS 1618 W. North Ave. Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-68	
24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR MORTON & DYETT		ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

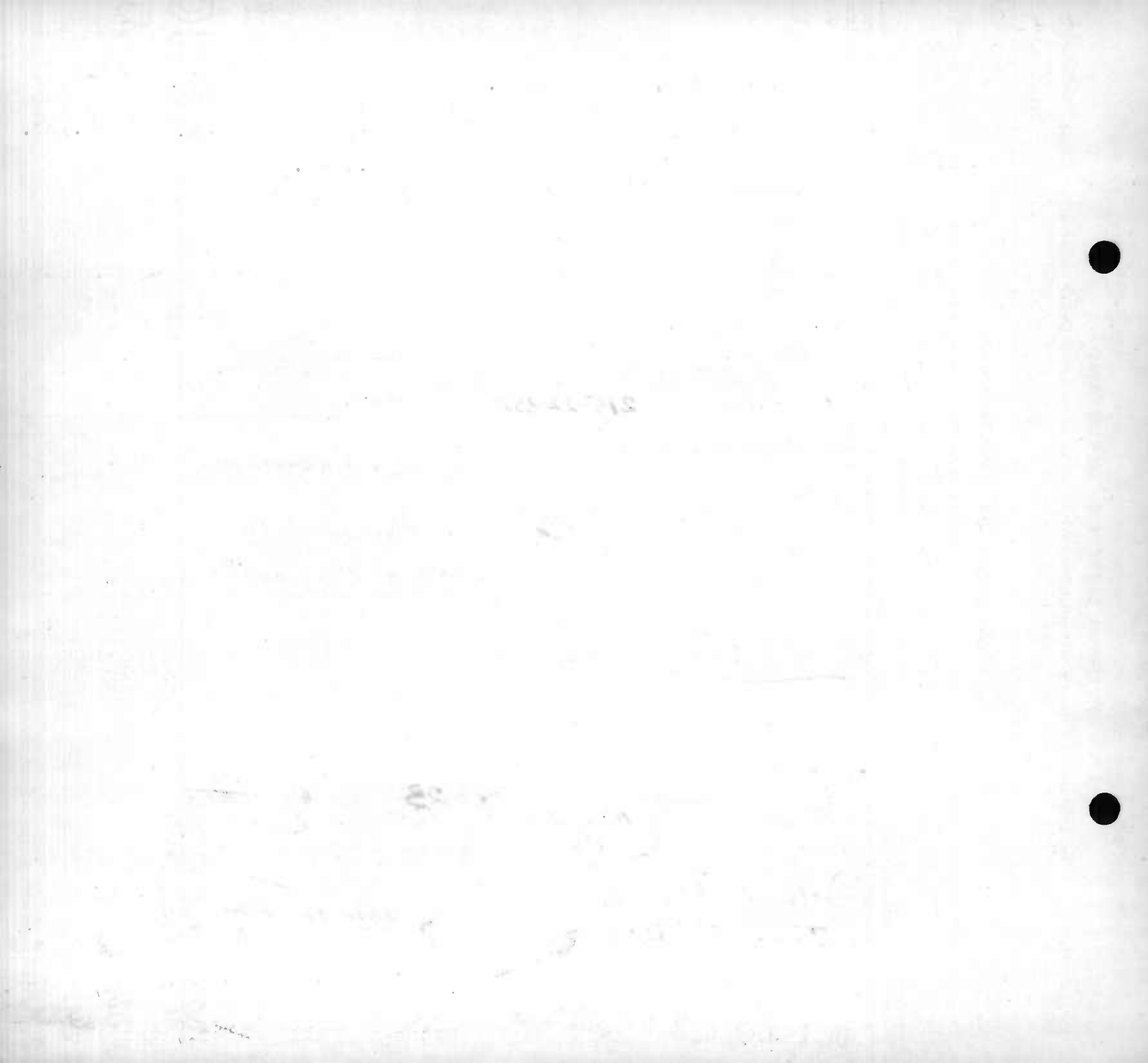
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6726	
<div style="display: flex; justify-content: space-between;"> 68-6726 F420 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		JEANNE L. FOWLKS <i>Jeanne Fowlks</i>		2. DATE AND HOUR OF DEATH <i>6/28/68 1104 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN <i>Balto</i>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>108 Oak St.</i> 21222	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/3/29</i>		9. AGE (In years last birthday) <i>39</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH			14. MOTHER'S MAIDEN NAME ELOUISE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>212-28-9910</i>		
			17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		
18. <i>4319 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial Bleed</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 1/2 hrs</i>					
19. <i>331X II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>8</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <i>6:30 PM 6/28/1968</i> to <i>11:30 PM 6/28/1968</i> , that (I) <u>(we)</u> lost saw the deceased olive on <i>6/28</i> 19 <i>68</i> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <i>Neil R. Williamson</i>				23B. DATE SIGNED <i>6/28/68</i>	
23C. PHYSICIAN'S NAME (Type) NEIL R. WILLIAMSON				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE <i>7-3-68</i>		24C. NAME of CEMETERY or CREMATORY MT. CALVARY	
24D. LOCATION (City, town, or county) (State) A.A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR MORTON + Dyett	
				ADDRESS 1701 LAWRENS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6727</u>	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>68-6727</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>Bosworth, Toussaint L.</u>			2. DATE AND HOUR OF DEATH <u>June 25, 1968</u> <u>5:52</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Balto., Md.</u> B. COUNTY <u>Balto., Md.</u>		
5. SEX <u>M</u>			6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH <u>6/6/30</u>		9. AGE (In years lost birthday) <u>38</u>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank Bosworth</u>			14. MOTHER'S MAIDEN NAME <u>Williams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>			16. SOCIAL SECURITY NO. <u>215-22-3521</u>		17. INFORMANT <u>chart</u>
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PROBABLE ARRHYTHMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
			(B) <u>PRIMARY Myocardial Disease</u>		<u>2 yrs</u>
			(C) <u>COXSACKIE Myocarditis</u>		<u>2 yrs</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>096.9 II</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 23</u> 19 <u>68</u> to <u>May 27</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 27</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John F. Rogers</u>			23B. DATE SIGNED <u>6/28/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>JOHN F. ROGERS</u>			23D. ADDRESS <u>UNIV. OF MARYLAND HOSPITAL DEPT OF MEDICINE</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24B. DATE <u>6/29/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK CREMATORY</u>	
				24D. LOCATION (City, town, or county) (State) <u>3801 Fredrick Avenue, Balto.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkner</u>		25C. FUNERAL DIRECTOR <u>Morton E. Pyett</u>	
				ADDRESS <u>Balto., Maryland</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68-6728

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MURRAY, Oscar Jr.		2. DATE AND HOUR OF DEATH June 27, 1968 10:55 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10B. KIND OF BUSINESS OR INDUSTRY Unknown		8. DATE OF BIRTH APRIL 1, '28	
13. FATHER'S NAME Oscar Murray Sr.		14. MOTHER'S MAIDEN NAME Eileen Nancy		9. AGE (In years last birthday) 40	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 246-28-0478		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		17. INFORMANT Records V. A. Hospital, Baltimore, Md. 21218			
18. 465X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 465X		Post-Operative Excision of Ileo Cutaneous Fistula			
19A. DATE OF OPERATION 3-12-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from June 24, 19 68 to June 27, 19 68 , that (B) (we) last saw the deceased alive on June 27, 19 68 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) XXXX view the body after death.					
23A. SIGNATURE Carlos R. Hamilton Jr.				23B. DATE SIGNED 6-28-68	
23C. PHYSICIAN'S NAME (Type) CARLOS R. HAMILTON JR		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-2-68		24C. NAME OF CEMETERY or CREMATORY BALLO, NATIONAL BALD	
24D. LOCATION MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REG. DIR. Robert E. Feltner		25C. FUNERAL DIRECTOR MORTON & Dyer F.H., INC.			

Book 1-1000, National Ball

Morton & Dorr 111

B. 635

68- 6729

BALTIMORE CITY HEALTH DEPARTMENT

68- 6729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) LUCILLE BROADNAX		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> June 27, 1968		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1804 N. Dallas Street		3. DATE PRONOUNCED DEAD June 27, 1968		Month Day Year Hour		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05	
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2-2-1929		10. AGE (In years last birthday) 39	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1804 N. Dallas Street		
11. BIRTHPLACE (State or foreign country) Conway, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lester Deloatch			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Andell Peoples			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.		18. INFORMANT Warren Broadnax 1804 N. Dallas St.			
19. 398X		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 27, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-68		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cmty.		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Randolph J. Collick 2431 E. Oliver St.			

1942

1943

1944

1945

1946

James Delaney

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Charles F. Light

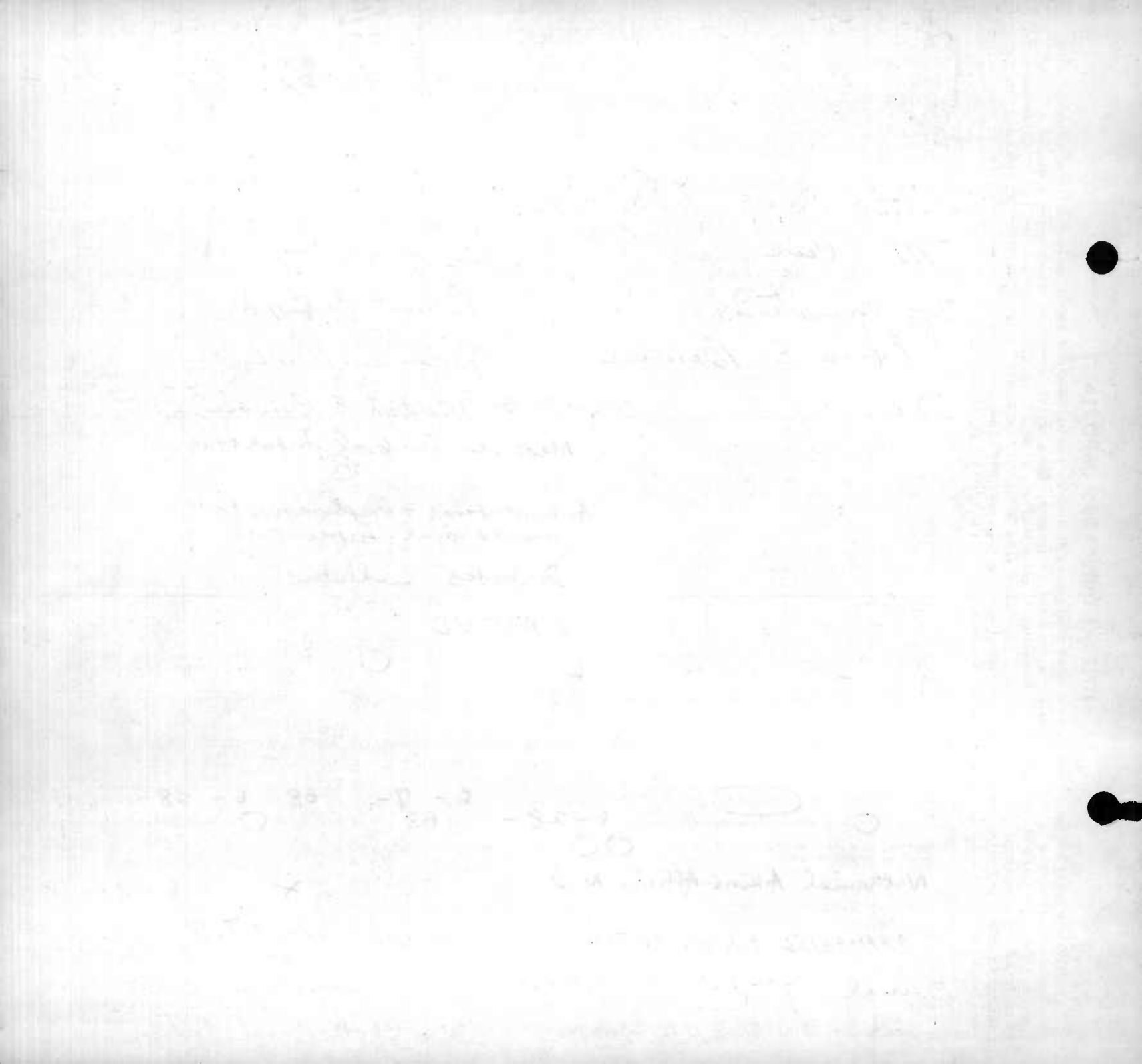
1-1-42 Mr. Colver, New York

1-1-42 Mr. Colver, New York

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-500 68-6730		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6730	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CLARENCE W. BOWEN</i>		2. DATE AND HOUR OF DEATH <i>6-28-68 4:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4 LAKE MANOR CT</i>					
5. SEX <i>M</i>	6. RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 19, 1894</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mrs. Monumental Bldg</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Calvert Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Oden E. Bowen</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Wilburn</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-1933</i>		17. INFORMANT <i>Mildred E. Bowen</i> ADDRESS: <i>4 Lake Manor Ct. Balto. 21210</i>	
18. <i>250191</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		<i>Massive Cerebral Infarction</i>			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anterolateral + Diaphragmatic Myocardial Infarction</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes mellitus</i>			
260X II		ASCVD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>8-1-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-7-1968</i> to <i>6-28-1968</i> , that (I) (we) last saw the deceased alive on <i>6-28-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nathaniel Aikins-Affili, M.D.</i>		23B. DATE SIGNED <i>6-28-68</i>		23C. PHYSICIAN'S NAME (Type) <i>NATHANIEL AIKINS-AFFILI</i>	
23D. ADDRESS <i>Mercy Hospital</i>					
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <i>Burial July 1, 68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine</i>		24D. LOCATION (City, town, or county) (State) <i>Woodlawn Balto Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbairn</i>		25C. FUNERAL DIRECTOR <i>Wm Cook-Banks-Townson</i> ADDRESS: <i>Townson Md</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>420-328</u>	
K-246		68- 6731		CERTIFICATE OF DEATH	
BIRTH NO. <u>68- 6731</u>		1. NAME OF DECEASED (Type or Print) <u>LUKA KOCHLER</u>			
2. DATE AND HOUR OF DEATH <u>6/25/68</u>		2. <u>2:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL OF BALTO.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>F.</u>			6. RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>1/21/86</u>		9. AGE (In years last birthday) <u>82</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>			12. CITIZEN OF WHAT COUNTRY? <u>US</u>		
13. FATHER'S NAME <u>William Sticks</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>D. J. PRADHAN</u> ADDRESS <u>Sinai Hospital</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		? Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ? Pulmonary embolism. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ 13-4X II Aspiration Pneumonia.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Aspiration Pneumonia.</u>					
19A. DATE OF OPERATION <u>16/16/68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>canal & anal</u>		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>6/13</u> 19 <u>68</u> to <u>6/25</u> 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>6/25</u> 19 <u>68</u> and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				23B. DATE SIGNED <u>6/25/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. J. PRADHAN, M.D.</u>				23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/29/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>London Park</u>	
24D. LOCATION (City, town, or county) <u>Baltimore - Maryland</u>		24E. (State) _____			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Edwin S. Mac Math Jr</u> ADDRESS <u>Catoonsville Md</u>	

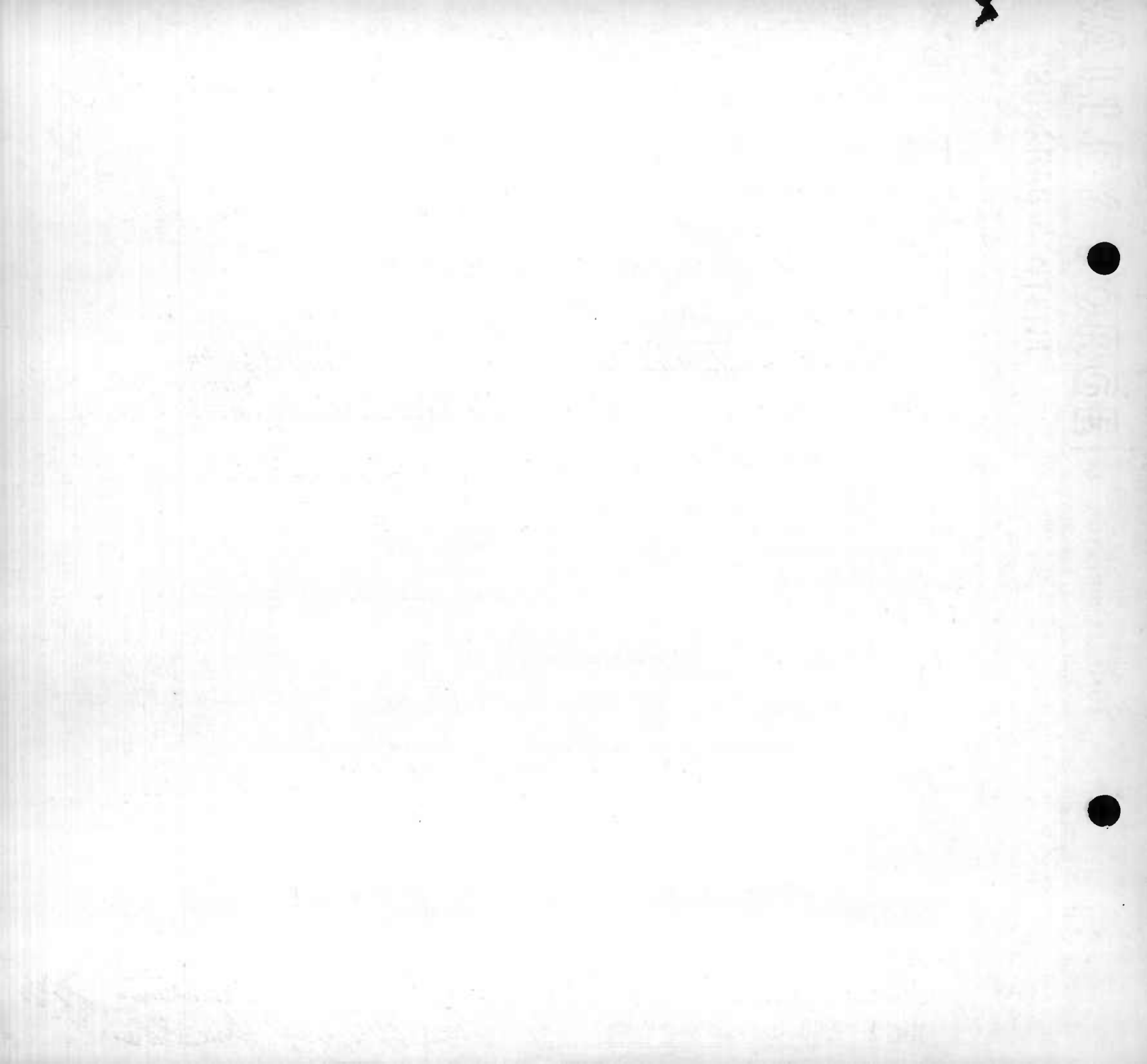
Dr. J. H. ...

...
...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6732	
<p>L-220 68- 6732 CERTIFICATE OF DEATH</p>					
1. NAME OF DECEASED (Type or Print) <i>Pearl Lucas</i>		2. DATE AND HOUR OF DEATH <i>June 24, 1968 12:30 p. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>2641 Frederick Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 12, 1889</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Harry H. Tillman</i>		14. MOTHER'S MAIDEN NAME <i>Sally Kuper</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-0802</i>		17. INFORMANT <i>Mr. John Tillman, Rt. 2 Box 198</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>45-1-91</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Massive pulm. embolism</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Thrombophlebitis</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>463X II</i></p>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>6/20</i> 19<i>68</i> to <i>6/24</i> 19<i>68</i>, that (I) (we) last saw the deceased alive on <i>6/24</i> 19<i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <i>Hasheem M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>M. J. Hasheem M.D.</i>	
23D. ADDRESS		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		23F. FUNERAL DIRECTOR	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <i>1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Oline Cemetery</i>	
24D. LOCATION (City, town or county) (State) <i>Randallstown Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>	
24G. ADDRESS		24H. NAME OF REGISTRAR		24I. NAME OF REGISTRAR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6733	
5-356 68- 6733 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MARGARET R. STINEHART</i>		2. DATE AND HOUR OF DEATH <i>JUNE 27, 1968 6:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>BALTO</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 MONTBELLO STATE HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH <i>JAN 28, 1915</i> 9. AGE (In years last birthday) <i>53</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>William Gerstmyer</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Strebeck</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-01-2043</i>	
17. INFORMANT <i>Paul Stinehart</i>		ADDRESS <i>Same</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>431.0</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i>		<i>1 hr.</i>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Dis.</i>		<i>8 yrs.</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Hypertension-Arterio-sclerosis</i>		<i>15 yrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>331X II</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Aug 22 1967</i> to <i>June 28 1968</i> , that (I) <i>we</i> last saw the deceased alive on <i>June 28 1968</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>we</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Raymond W. Herrmann</i>				23B. DATE SIGNED <i>6-28-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Raymond W. Herrmann</i>				23D. ADDRESS <i>Montebello Hosp Balt.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-1-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Johns Evan. Luth.</i>	
24D. LOCATION <i>Parkville, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc., 5305 Harford Rd.</i>			

WALL

50-87-35 1LB

S-512 68-6734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-6734

BIRTH NO.

NAME OF DECEASED
(Type or Print)

ELIZABETH SIMPSON

Marie

DATE AND HOUR OF DEATH

JUNE 29 1968 12:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTIONIF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital
314940 EASTERN AVE.
BALTO., MD. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

E. STREET AND NUMBER

F. CITY OR TOWN

G. STREET AND NUMBER

H. CITY OR TOWN

I. STREET AND NUMBER

J. CITY OR TOWN

K. STREET AND NUMBER

L. CITY OR TOWN

M. STREET AND NUMBER

N. CITY OR TOWN

O. STREET AND NUMBER

P. CITY OR TOWN

Q. STREET AND NUMBER

R. CITY OR TOWN

S. STREET AND NUMBER

T. CITY OR TOWN

U. STREET AND NUMBER

V. CITY OR TOWN

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X. CITY OR TOWN

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AA. STREET AND NUMBER

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AC. STREET AND NUMBER

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BF. CITY OR TOWN

BG. STREET AND NUMBER

BH. CITY OR TOWN

BI. STREET AND NUMBER

BJ. CITY OR TOWN

5. SEX

6. RACE

7. MARRIED

8. NEVER MARRIED

9. DATE OF BIRTH

10. AGE (In years)

11. Under 1 Yr.

12. Under 24 Hrs.

13. Under 1 Yr.

14. Under 24 Hrs.

15. Under 1 Yr.

16. Under 24 Hrs.

17. Under 1 Yr.

18. Under 24 Hrs.

19. Under 1 Yr.

20. Under 24 Hrs.

21. Under 1 Yr.

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25. Under 1 Yr.

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237. Under 1 Yr.

238. Under 24 Hrs.

239. Under 1 Yr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
68-6735				Maud Backert				6/29/68 11:30 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital								A. STATE Md.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)								B. COUNTY Baltimore			
								C. CITY OR TOWN Baltimore			
								D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
								E. STREET AND NUMBER 427 E. Belvedere Ave			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/4/94		9. AGE (In years lost birthday) 74		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Pedvin				14. MOTHER'S MAIDEN NAME Virginia Hayden				17. INFORMANT George C. Backert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-071-1649B				17. ADDRESS Same as deceased			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10/9 I				CAUSE OF DEATH (A) Massive Myocardial Infarct.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II				(B) A SCVD (C) RUPTURE 2 HEART E CARS 2 TAPS MADE				years MIN 8			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 6/29 6/27 68 to 6/29 68 that (I) (we) last saw the deceased alive on 6/29 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Sinden Truth and				23B. DATE SIGNED 6/29/68							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc		ADDRESS Baltimore, Maryland					

X

34

3200

28/1

Bill D. Anderson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6736	
C-621		68-6736		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Louise Crisafulli			2. DATE AND HOUR OF DEATH 6/30/68		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO E. STREET AND NUMBER 2615 Huntington Ave.		
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/30/95	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Bova			14. MOTHER'S MAIDEN NAME Anna X Scalo		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-8141		17. INFORMANT Hospital Records	
18. 25-0191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Diabetes Mellitus			CAUSE OF DEATH Acute Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) Volubus large bowel		
19A. DATE OF OPERATION 260X II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 6/28/68 to 6/30/68 , that (we) last saw the deceased alive on 6/30/68 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald M. Wood MD			23B. DATE SIGNED 6-30-68		
23C. PHYSICIAN'S NAME (Type) Donald M. Wood			23D. ADDRESS So. Balto. General Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leona rd J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6737
<div style="display: flex; justify-content: space-between;"> B- 652 68- 6737 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <i>Clarence H. Barnes</i>		2. DATE AND HOUR OF DEATH <i>6-26-68</i> <i>8</i> <i>P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Union Memorial</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____ C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>521 N. Schroeder St.</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-31-15</i>	9. AGE (In years last birthday) <i>53</i>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stewart</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Saunders</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>P</i>		14. MOTHER'S MAIDEN NAME <i>P</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-14-9934</i>		17. INFORMANT ADDRESS	
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: <i>45-min</i> (B) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>76 months</i> (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-26-68</i> 19 to <i>6-26-68</i> 19, that (I) (we) last saw the deceased alive on <i>6-28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joe T. Chandler MD</i>		23B. DATE SIGNED <i>6-26-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Joe T. Chandler MD</i>	
23D. ADDRESS <i>The Union Memorial Hosp.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>7/1/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Arbutus Belto. Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber</i>		25C. FUNERAL DIRECTOR <i>Stinson & Wilson Balto. ST</i>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6738	
BIRTH NO. 11-250 68- 6738				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mason Charles			2. DATE AND HOUR OF DEATH June 26, 1968 1:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Home 27 N. Carey Street			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male 6. RACE Negro			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-1896
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			11. BIRTHPLACE (State or foreign country) Unknown		9. AGE (In years last birthday) 72
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? Unknown
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-12-6635A		17. INFORMANT ADDRESS
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 332x II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 18 1967 to June 26 1968 , that (I) (we) last saw the deceased alive on June 26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hollis Seunarine, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE				23D. ADDRESS 5519 Kennison Av Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial 6/29/68		mt Calver		Blackburn Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Shirley D. Clark	

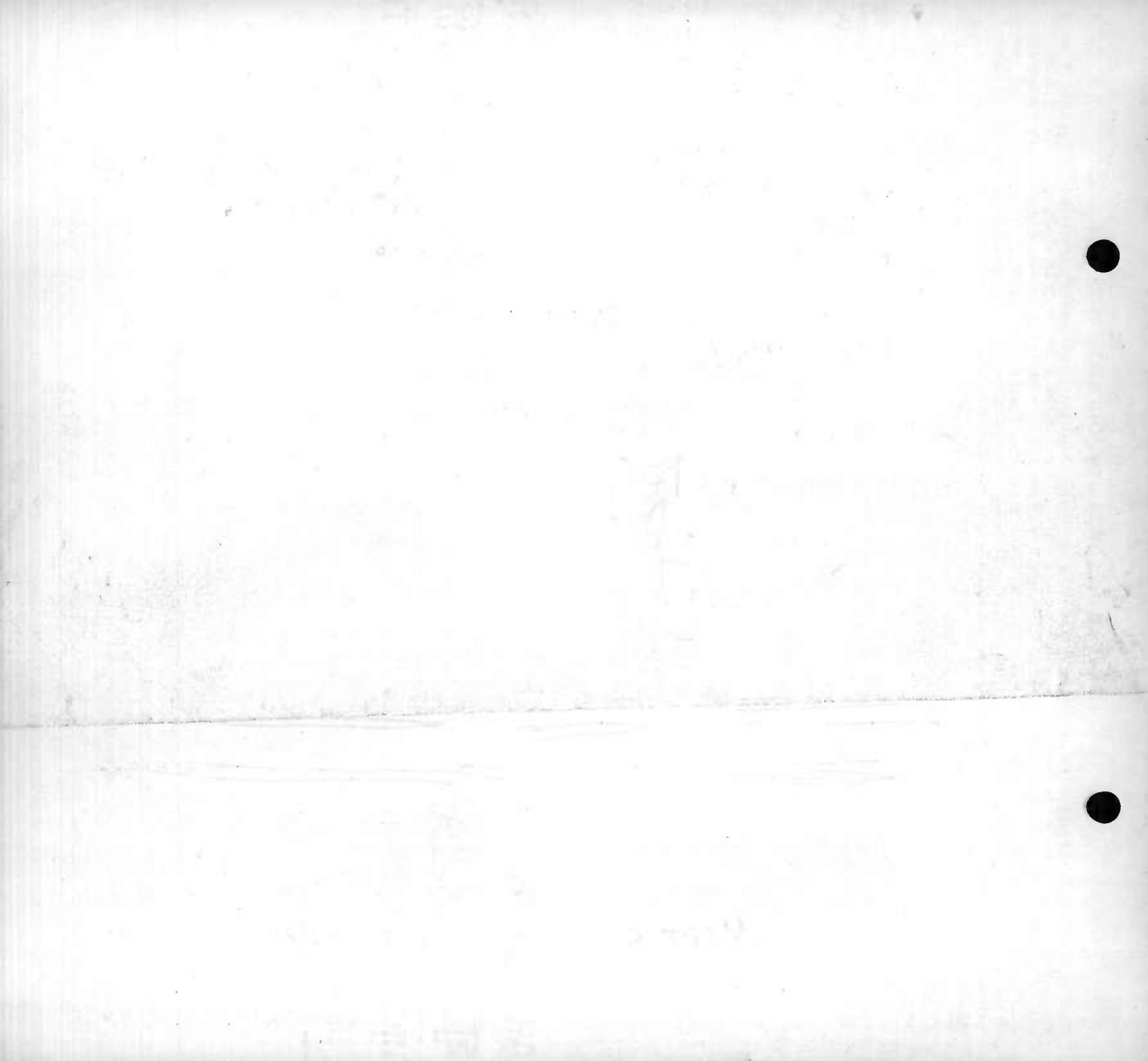
~~James J. [illegible]~~

James J. [illegible] 23rd Tennessee 4th Regt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

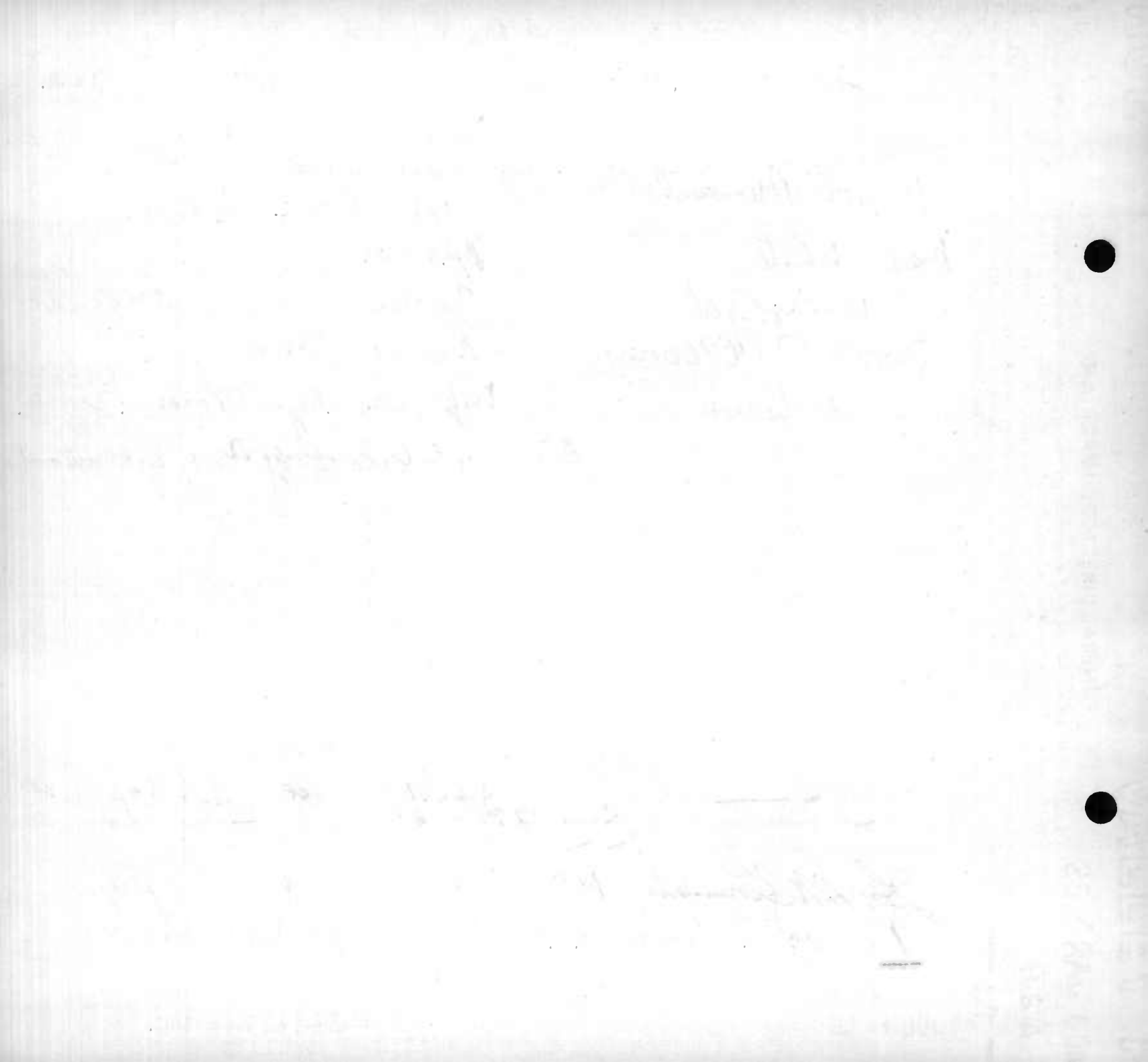
<div style="display: flex; justify-content: space-between;"> M-460 68- 6739 BALTIMORE CITY HEALTH DEPT. </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		68- 6739 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) (SIMON BERNARD MULLER)	
2. DATE AND HOUR OF DEATH 6/29/68 145 P M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 483012 Abell Ave	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 483012 Abell Ave	
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 3012 Abell Ave	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/14/68
9. AGE (In years lost birthday) 83		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOK KEEPER		10B. KIND OF BUSINESS OR INDUSTRY RETIRED B.&O. RR.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? MARYLAND USA	
13. FATHER'S NAME John Muller		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 4415 705-03-445	
17. INFORMANT Janina Chant		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4407 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Vascular disease	
ANTECEDENT CAUSE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Smoking DUE TO, OR AS A CONSEQUENCE OF:	
(C) Dehydration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 0	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6/16/68 to 6/29/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE MARTER		23B. DATE SIGNED 6/29/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS Md General Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1968	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Henry Sander & Sons, Inc.	
25C. FUNERAL DIRECTOR Baltimore Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6740	
<div style="display: flex; justify-content: space-between;"> C-160 68- 6740 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
LILLIE G. COOPER			JUNE 30, 1968 10 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em;">90</div> Harford Gardens Convul.Home 4700 Harford Road			A. STATE B. COUNTY <div style="font-size: 1.5em;">9-06</div> MARYLAND C. CITY OR TOWN BALTIMORE 21218 D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1704 East 32nd. Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 25, 1872	95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Samuel Wright			Susan Mills		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		218 52 0525 J 1		Mrs Gladys C. Stavely 1704 E 32ND ST.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Arteriosclerotic Cardio-vascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 11 19 68 to June 30 19 68, that (I) (we) last saw the deceased alive on June 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (They) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
<div style="font-size: 1.5em;">Loy M. Zimmerman M.D.</div> DEGREE			7/1/68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Loy M. Zimmerman M.D.			3202 Harford Road		
24A. BURIAL CREMATION REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
7/3/68		Unity Washington Cemetery		Hurlock Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 1 1968		Robert E. Fisher		HENRY SANDER & SONS INC. BALTIMORE MARYLAND	



FUNERAL DIRECTOR: IMPORTANT

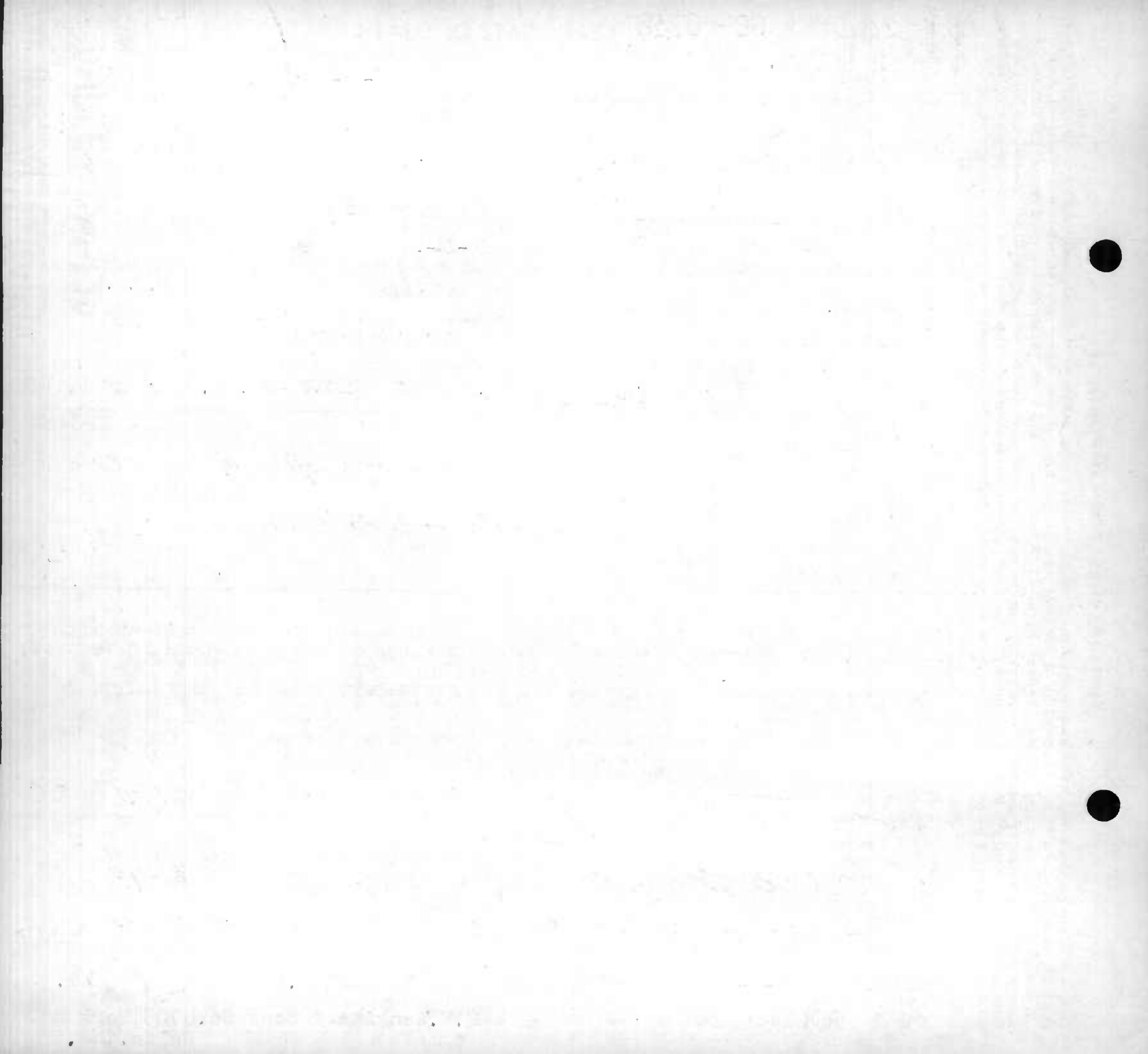
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6741
<div style="display: flex; justify-content: space-between;"> O-256 68- 6741 CERTIFICATE OF DEATH </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) JOSEPH P. O'CONNOR			2. DATE AND HOUR OF DEATH 6/29/68 4:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 14 W. Cold Spring Lane		
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/20	9. AGE (In years, months, days) 47 Years	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work) Steam Ship Management		10B. KIND OF BUSINESS OR INDUSTRY Central OIL		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME JOSEPH P. O'CONNOR			
14. MOTHER'S MAIDEN NAME Naomi Dean		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO			
16. SOCIAL SECURITY NO. 218-10-8941		17. INFORMANT Wife Geraldyn O'Connor			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 16311 I		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung w/ metastases (B) DUE TO, OR AS A CONSEQUENCE OF: Orchitis pneumonia (C) _____			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 164X II		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Y.S			
19A. DATE OF OPERATION 6/29/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that Union Memorial Hospital (this hospital) attended the deceased from 6/29/68 to 6/29/68 , that (I) Robert E. Sander last saw the deceased alive on 6/29/68 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) Yes (did) not view the body after death.					
23A. SIGNATURE Robert E. Sander			23B. DATE SIGNED 6/29/68		23C. ADDRESS THE UNION MEMORIAL HOSPITAL
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR Robert E. Sander		25C. FUNERAL DIRECTOR HENRY SANDER & SONS INC.			
25D. ADDRESS BALTIMORE MARYLAND 21213					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

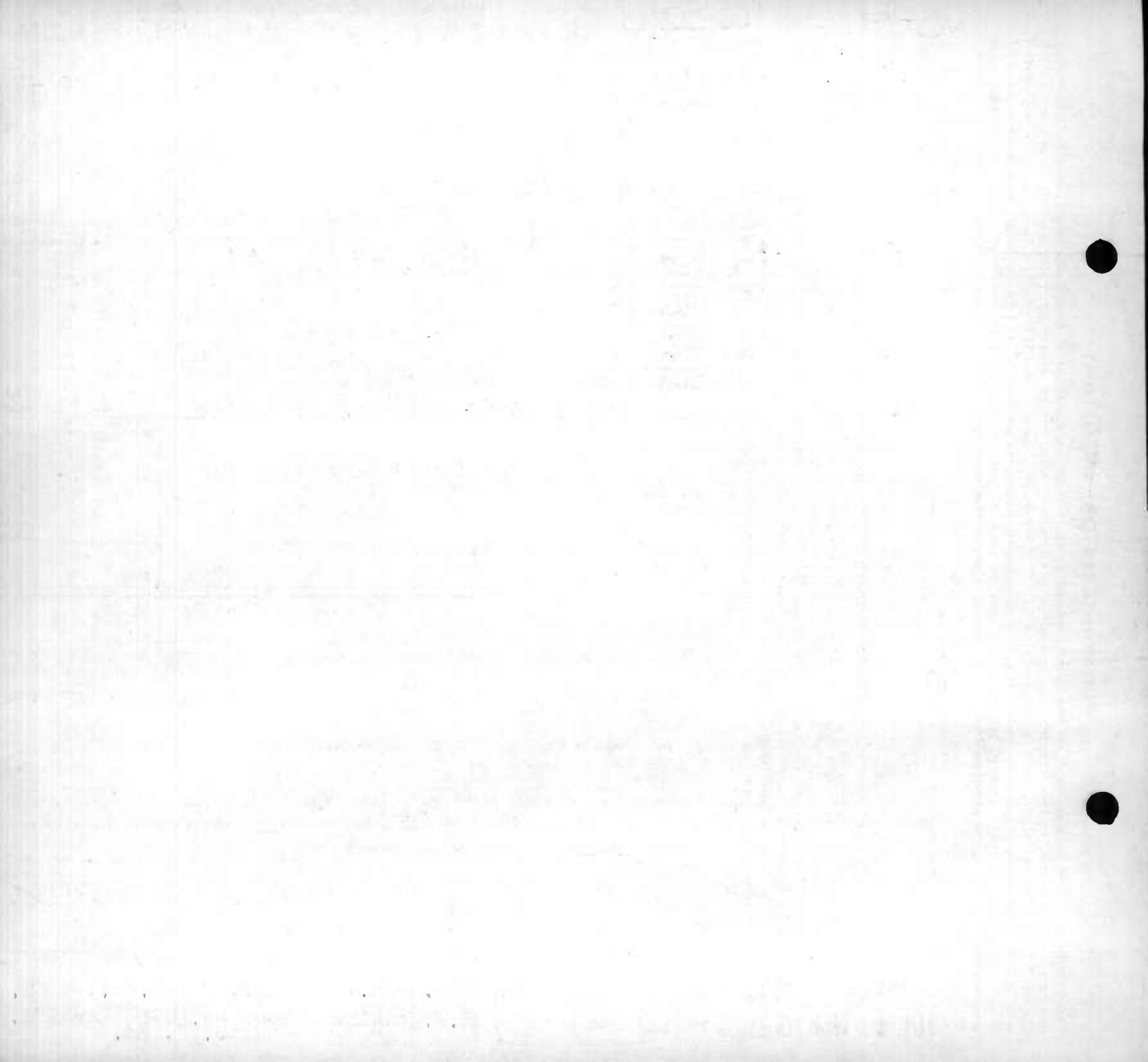
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6742</u>	
<div style="display: flex; justify-content: space-between;"> 7-260 68-6742 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>VIRGINIA FISHER</u>		2. DATE AND HOUR OF DEATH <u>6-29-1968</u> <u>7:55</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 BOLTON HILL NURSING CENTER</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto Co.</u> <u>53-00</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>215 CLARENDON AVE</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-84</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM GINN</u>			14. MOTHER'S MAIDEN NAME <u>COOKE (Virginia)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-2304B</u>	17. INFORMANT <u>ADMISSION RECORD - Wm. G. Fisher (Son)</u>		
18. <u>412.4</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary insufficiency</u> (B) <u>antecedent to U.D. disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4-20-1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> 19 <u>66</u> to <u>6/29</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 29</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Alan H. Macht MD</u> DEGREE				23B. DATE SIGNED <u>6/28/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MACHT MD</u> DEGREE				23D. ADDRESS <u>2 E Real St Balto Md 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-2-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>	
				ADDRESS <u>4905 York Rd. Balto., Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

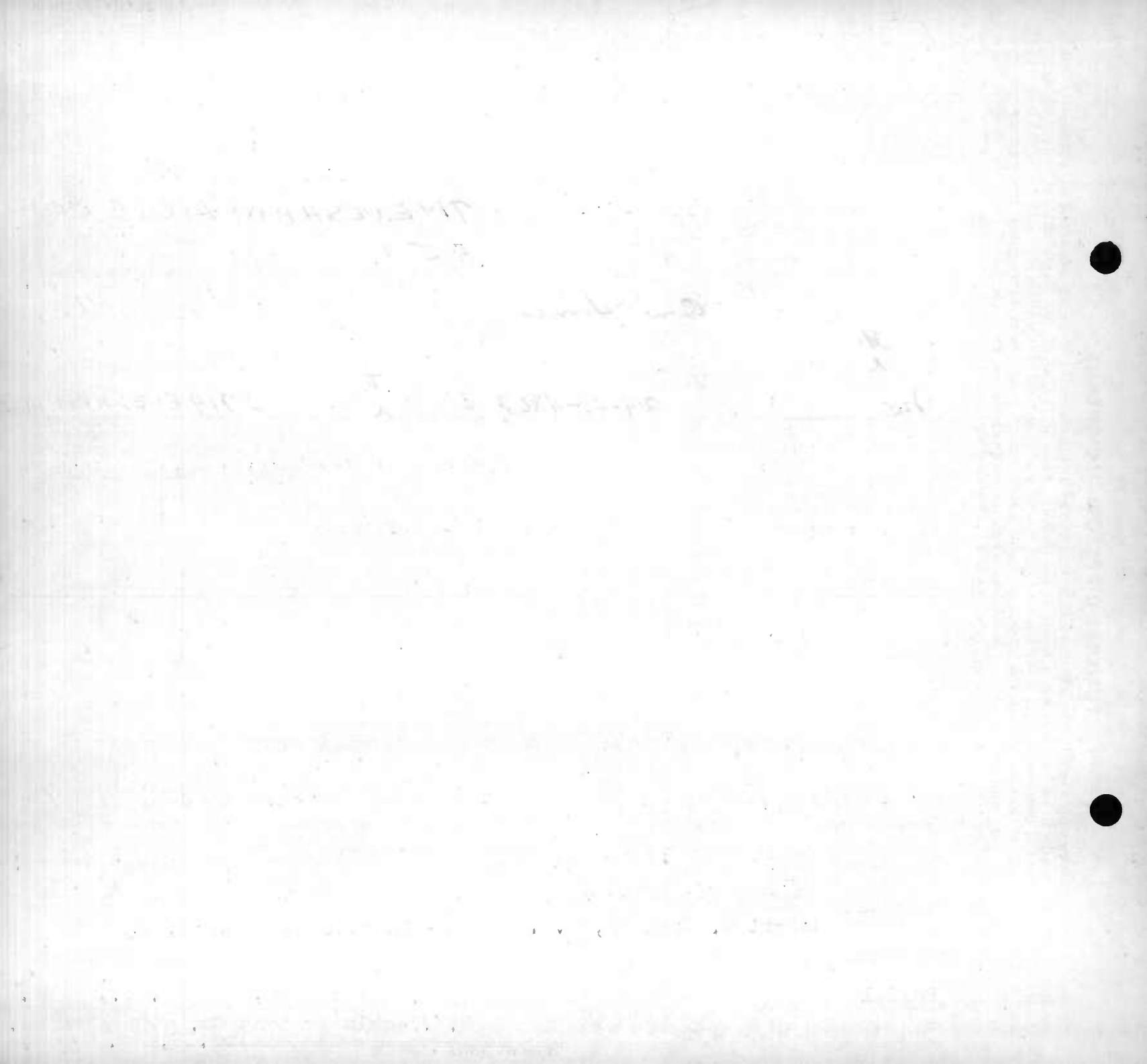
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6743
5-316		68-6743		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Laura Helen Stover		June 30, 1968 9:00 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
36 Franklin Square Hospital		Md. Baltimore 53-00		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Towson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		605 Coventry Rd.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
F	W		11/20/98	69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		OWN HOME		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Jerome W. Hoover		ELIZABETH (Lizzie) Fishpaw		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		215 01 7768-B		Gilbert M. Stover, 606 Coventry Rd., 21208
18. 153.8 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		Colon carcinoma		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
May 29, 68	poor	No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?		
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 20 1968 to June 30 1968, that (I) (we) last saw the deceased alive on June 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
Hyung K. Lee, M.D.				June 30, 1968
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Hyung Kon Lee, M.D.		100 N. Calhoun St. Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	7/2/1968	Dulaney Valley Mem. Brds. Timonium, Balto. Co., Md.		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
JUL 1 1968	Robert E. Fisher			H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6744	
<div style="display: flex; justify-content: space-between;"> B-652 68- 6744 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Barnes, Monte Elizabeth</i>		2. DATE AND HOUR OF DEATH <i>6/29/68 11:20 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <i>91 Montebello State Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>719 E. ESHAM AVENUE 21212</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5/5/98</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USC.</i>
13. FATHER'S NAME <i>John Wallenberg</i>			14. MOTHER'S MAIDEN NAME <i>Minnie Hornet</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-40-4863</i>	17. INFORMANT <i>T. Lloyd Barnes</i> ADDRESS <i>719 E. ESHAM AVE</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Bilateral pneumonia</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk.</i>		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) <i>multiple strokes</i>		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
334X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>4/12</i> 19 <i>66</i> to <i>6/29</i> 19 <i>68</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>6/29</i> 19 <i>68</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Robert W. Ireland</i>			23B. DATE SIGNED <i>6/29/68</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland, M.D.</i>			23D. ADDRESS <i>Montebello State Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>7/3/68</i>		<i>Woodlawn</i>	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
<i>Balto. Md.</i>		<i>Woodlawn, Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<i>JUL 1 1968</i>		<i>Robert E. Jenkins</i>		<i>H.W. Jenkins & Sons Co., 4905 York Rd. Balto. 12, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

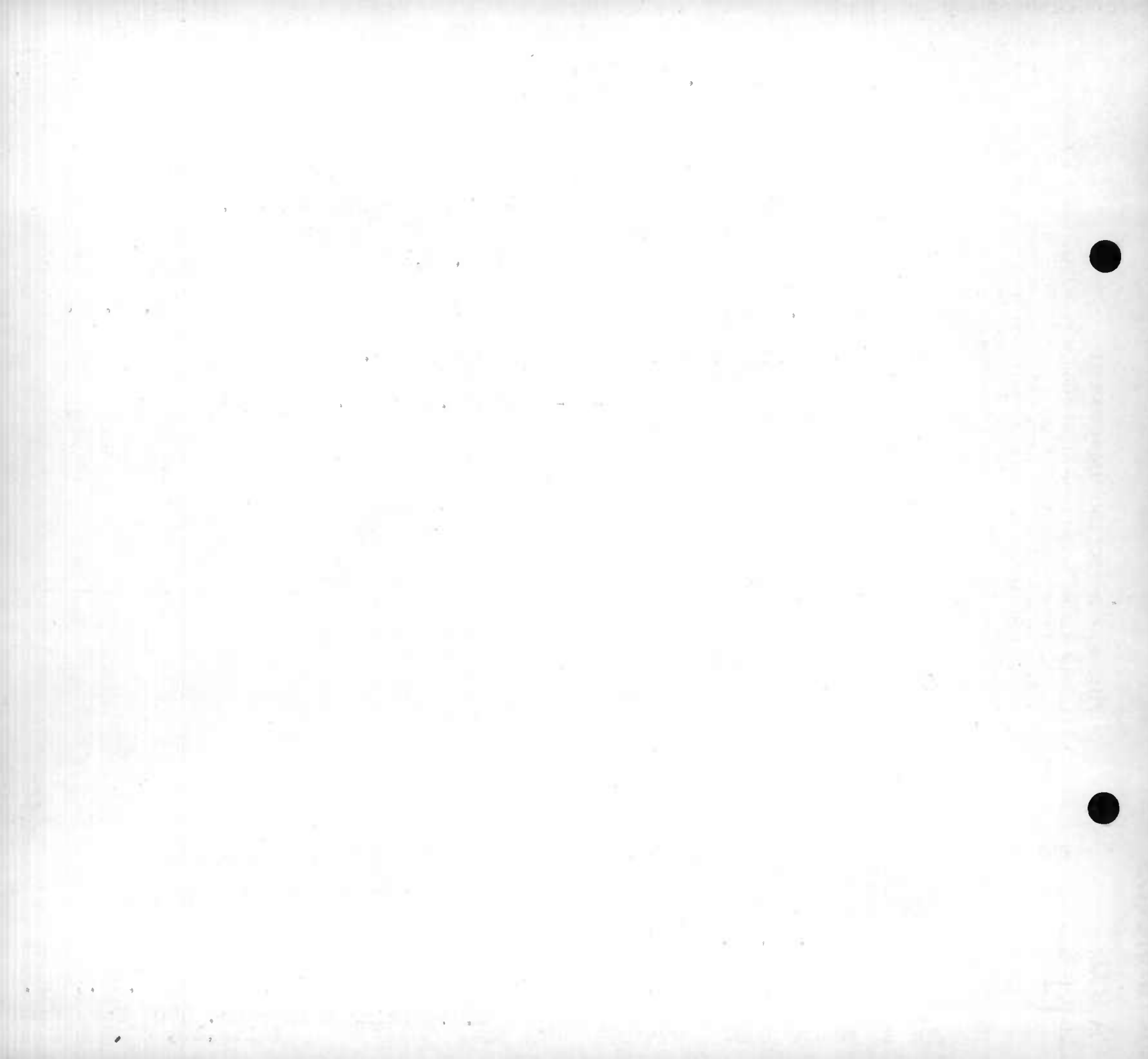
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
4-530		68- 6745		68- 6745	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) Mrs HAND, HANNAH TAYLOR </div> <div> 2. DATE AND HOUR OF DEATH 6/28/68 at 10.20 P.M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital </div> <div style="flex: 1;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE Maryland </div> <div style="flex: 1;"> B. COUNTY 21210 </div> </div>		
5. SEX Female			6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None		8. DATE OF BIRTH 06-06-11	
13. FATHER'S NAME HOWARD R. TAYLOR		14. MOTHER'S MAIDEN NAME HANNAH F. STEUART.		9. AGE (In years last birthday) 57	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-0716		17. INFORMANT Dr F. G. YASSA, M.D.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 682.0 I Encephalomalacia Cervical carotid artery right		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Abscess of neck, right DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 36/16/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED neck & removal of carotid A.		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Y.S.	
21D. TIME OF INJURY (Approx.) 		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 	
22. I certify that (I) (this hospital) attended the deceased from 6/16 1968 to 6/28 1968, that (I) (we) lost saw the deceased alive on 6/28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. F. G. Yassa, M.D.				23B. DATE SIGNED 6/28/68	
23C. PHYSICIAN'S NAME (Type) DR FAYEK G YASSA				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-29-68		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Baltimore, Md.	

2.X

FUNERAL DIRECTOR: IMPORTANT

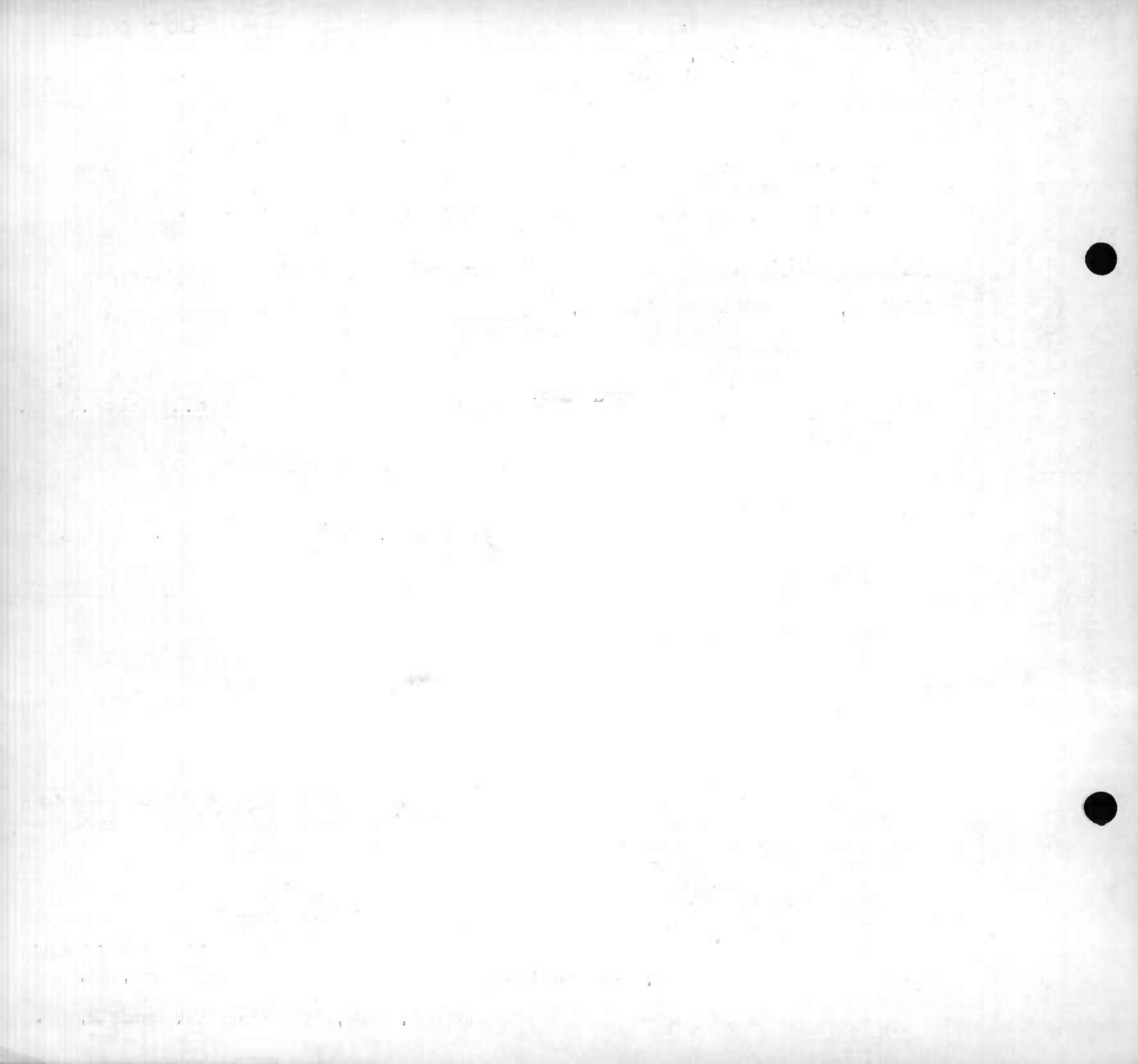
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6746	
C-524 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Eugene C. Council		2. DATE AND HOUR OF DEATH 6/30/68 3:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN Baltimore 21218		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 6, 1894		9. AGE (In years, last birthday) 74		10. If Under 1 Yr. Months; Days If Under 24 Hrs. Hours; Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Atty.		10B. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eugene Kincaid Council			
14. MOTHER'S MAIDEN NAME Birtie M. Kemp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-40-0370		17. INFORMANT Mrs. Marie A. Council (Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 144X I Carcinoma of the mouth		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the mouth (B) DUE TO, OR AS A CONSEQUENCE OF: Mouth (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 143X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/9/68 19 to 6/30/68 19 68 , that (I) (we) last saw the deceased alive on 6/30/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. R. L. Marby				23B. DATE SIGNED 6/30/68	
23C. PHYSICIAN'S NAME (Type) Dr. R. L. Marby				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Woodlawn Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968			
25B. NAME OF REGISTRAR E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

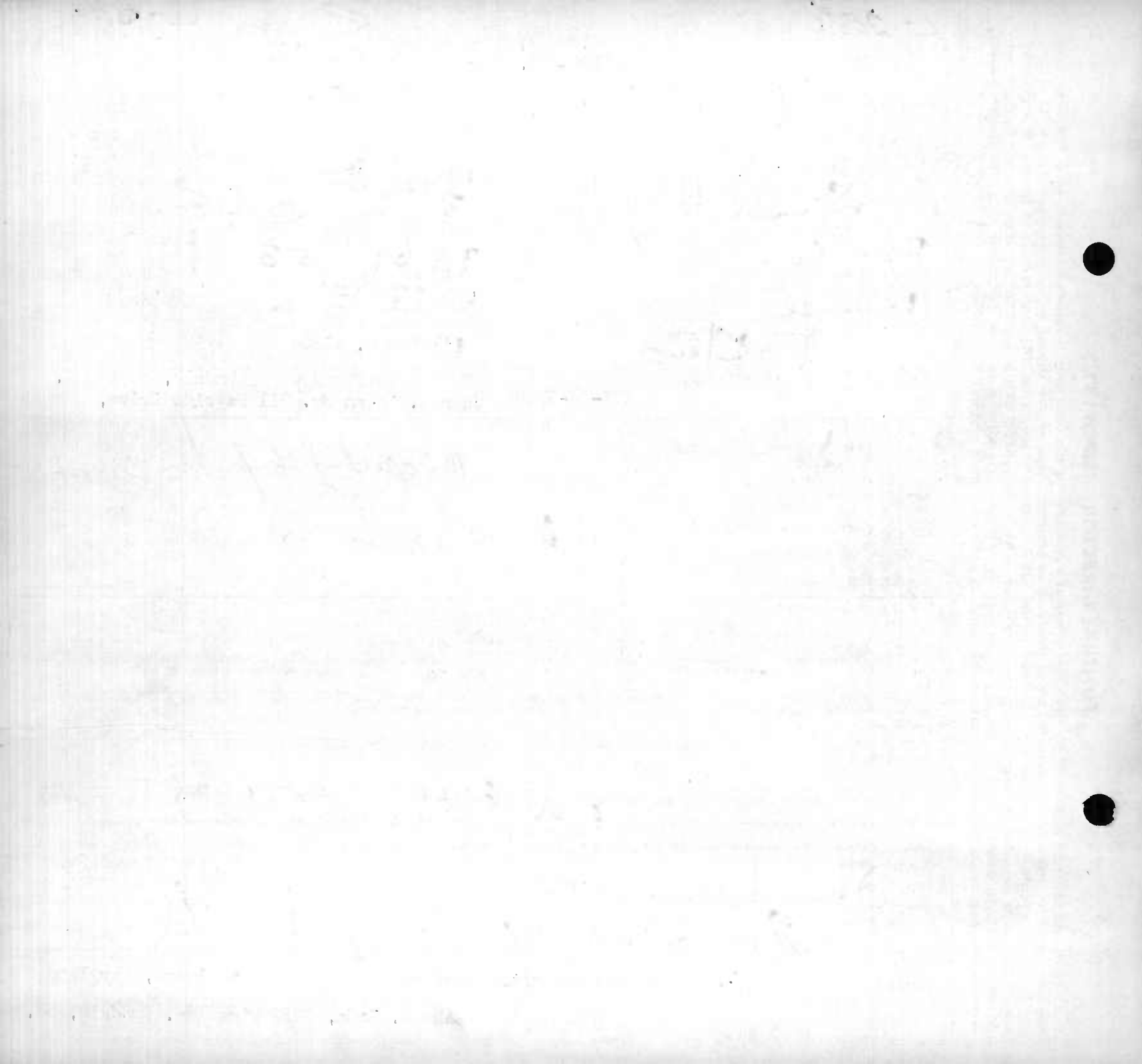
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6747	
BIRTH NO. M-500 68-6747				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) William P. Munn		2. DATE AND HOUR OF DEATH 6/26/68 3:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-27-14		9. AGE (In years, last birthday) 53		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millright,		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Fred MUNN		14. MOTHER'S MAIDEN NAME Murtie Munn	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-4212		17. INFORMANT ADDRESS Baltimore City Hospitals 21224 Records: 4940 Eastern Ave., Balto., Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 465-X II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SEPSIS, COR PULMONOE (B) CHRONIC PULMONARY EMBOLI (C)			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 1968 to 6/26 1968, that (I) (we) last saw the deceased alive on 6/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald E. Smith MD		23B. DATE SIGNED 6/26/68		23C. PHYSICIAN'S NAME (Type) Ronald E. Smith MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR John J. Duda	
25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

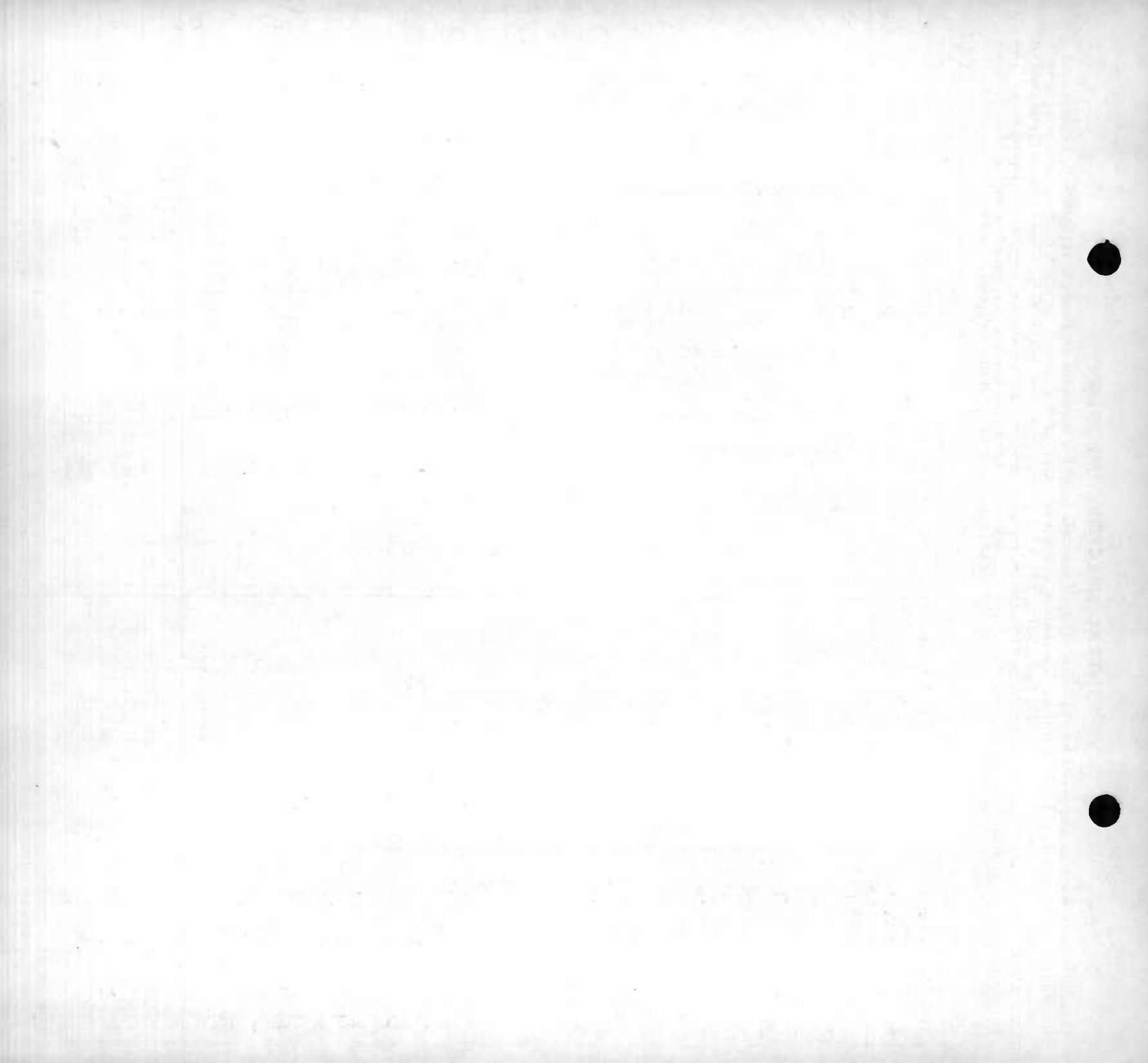
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6748
L-250 68-6748		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Logan, Mildred</i>		2. DATE AND HOUR OF DEATH <i>6-25-68 1145 P.M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 Sinai Hospital</i>		C. CITY OR TOWN <i>Dundalk</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <i>311 Bayside Dr.</i>		
5. SEX <i>Female</i>	6. RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/5/09</i>	9. AGE (In years lost birthday) <i>58</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>
13. FATHER'S NAME <i>Harry R. Klaus</i>		14. MOTHER'S MAIDEN NAME <i>Lillian M. Sietz</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>172-05-3358</i>		17. INFORMANT (Husband) <i>Dundalk, ADDRESS Md.</i> <i>John R. Logan Sr. 311 Bayside Drive,</i>
18. <i>410.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) <i>Arterial occlusion</i> DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>
MEDICAL CERTIFICATION				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>420.1 II</i>				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>6-24-68</i> to <i>6-25-68</i> , that (I) (we) last saw the deceased alive on <i>6-25-68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Sam LeBauer MD</i>		23B. DATE SIGNED <i>6-25-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Sam LeBauer MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/29/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cemetery</i>
24D. LOCATION <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		
25B. NAME OF REGISTRAR <i>John J. Duda</i>		25C. FUNERAL DIRECTOR <i>John J. Duda, 7922 Wise Ave. Dundalk, Md.</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-242		68- 6749		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6749	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				WALTER T. WESOLOWSKI		2. DATE AND HOUR OF DEATH June 28, 1968 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
33 JOHNS HOPKINS HOSPITAL				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1228 Glenhaven Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/10/24	43			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Self-employed		Wall paper Business		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Wesolowski				Stanislawa Dziennik			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No -		218-18-5043		Mrs. Frances Wesolowski, 1228 Glenhaven Road			
1B. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intervascular heart disease</i> 13 yr. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <i>July 7 1955</i> to <i>Feb 8 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 8 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<i>Joseph D B King</i>				6/29/68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOSEPH D B KING				2 HAMILL RD 21210			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (State)	
Burial		7/2/68		Holy Rosary		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 1 1968		<i>Robert E. Jankins</i>		M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 68- 6750				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6750	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carl W. Bruce				2. DATE AND HOUR OF DEATH 6-28-68 7:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.				A. STATE Maryland B. COUNTY # 212301			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenace				10B. KIND OF BUSINESS OR INDUSTRY NONE		9. AGE (In years last birthday) 51	
11. BIRTHPLACE (State or foreign country) Ohio				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Bruce				14. MOTHER'S MAIDEN NAME Sarah Webb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 798-12-044		17. INFORMANT Florence Bruce	
18. 2910 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Cerebral edema			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF Bronchopneumonia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Delirium Tremens			
				(C) Alcoholism Comp Fracture of scapula RT			
19A. DATE OF OPERATION 307X II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
22. I certify that (we) (this hospital) attended the deceased from 6-22 19 68 to 6-28 19 68 , that (we) last saw the deceased alive on 6-28 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Samadins				23B. DATE SIGNED 6-28-68		23C. PHYSICIAN'S NAME (Type) Abdolhossein Samadi, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-2-1968		24C. NAME OF CEMETERY or CREMATORY BUCK EYE	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968				25B. NAME OF REGISTRAR Robert E. Sawyer		25C. FUNERAL DIRECTOR Franklin Furnace	
				ADDRESS 1213 Light St.			
				LOCATION (City, town, or county) (State) FRANKLIN FURNACE CHIC			
				ADDRESS 8750 State St. 327 N. W. 11th Ave.			

10-17-17
X
10-17-17

South Baltimore General Hosp 601 So. Hanover St

6-18-17 21

Ohio

None

William

Sarah Webb

Yes

Abolition 20 March 1818 1945 St

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6751</u>
L-000		68- 6751		
BIRTH NO. _____				
1. NAME OF DECEASED (Type or Print) <u>William H. Lee</u>		2. DATE AND HOUR OF DEATH <u>June 27 1968 8⁰⁰ A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>629 Deepdore Road</u>		
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-07</u>	9. AGE (In years last birthday) <u>61</u> If Under 1 Yr. Manths: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Norris Ford</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>George Lee</u>		
14. MOTHER'S MAIDEN NAME <u>Sadie Schured</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		
16. SOCIAL SECURITY NO. <u>215-03-7415</u>		17. INFORMANT <u>Pt's chart</u> ADDRESS _____		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>560.9 I ANOXIC CEREBRAL DAMAGE P</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RESUSCITATION CARDIAC ARREST</u> <u>(B) RESECTION ILEUM 1°, ULCERATED & OBSTRUCTED</u> <u>(C) RADIATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>570.5 II</u>				
19A. DATE OF OPERATION <u>24 June 68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstruction bowel</u>		20A. AUTOPSY? (Yes or No) _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I certify that (I) (this hospital) attended the deceased from <u>23 June 1968</u> to <u>27 June 1968</u> , that (I) (we) last saw the deceased alive on <u>27 June 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sidney L. Stapleton, Jr. MD</u>		23B. DATE SIGNED <u>27 June 68</u>		23C. PHYSICIAN'S NAME (Type) <u>SIDNEY L. STAPLETON, JR. MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 1, 68</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. Cook-Brooks</u> ADDRESS <u>St. Paul & Preston Baltimore, Md.</u>		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

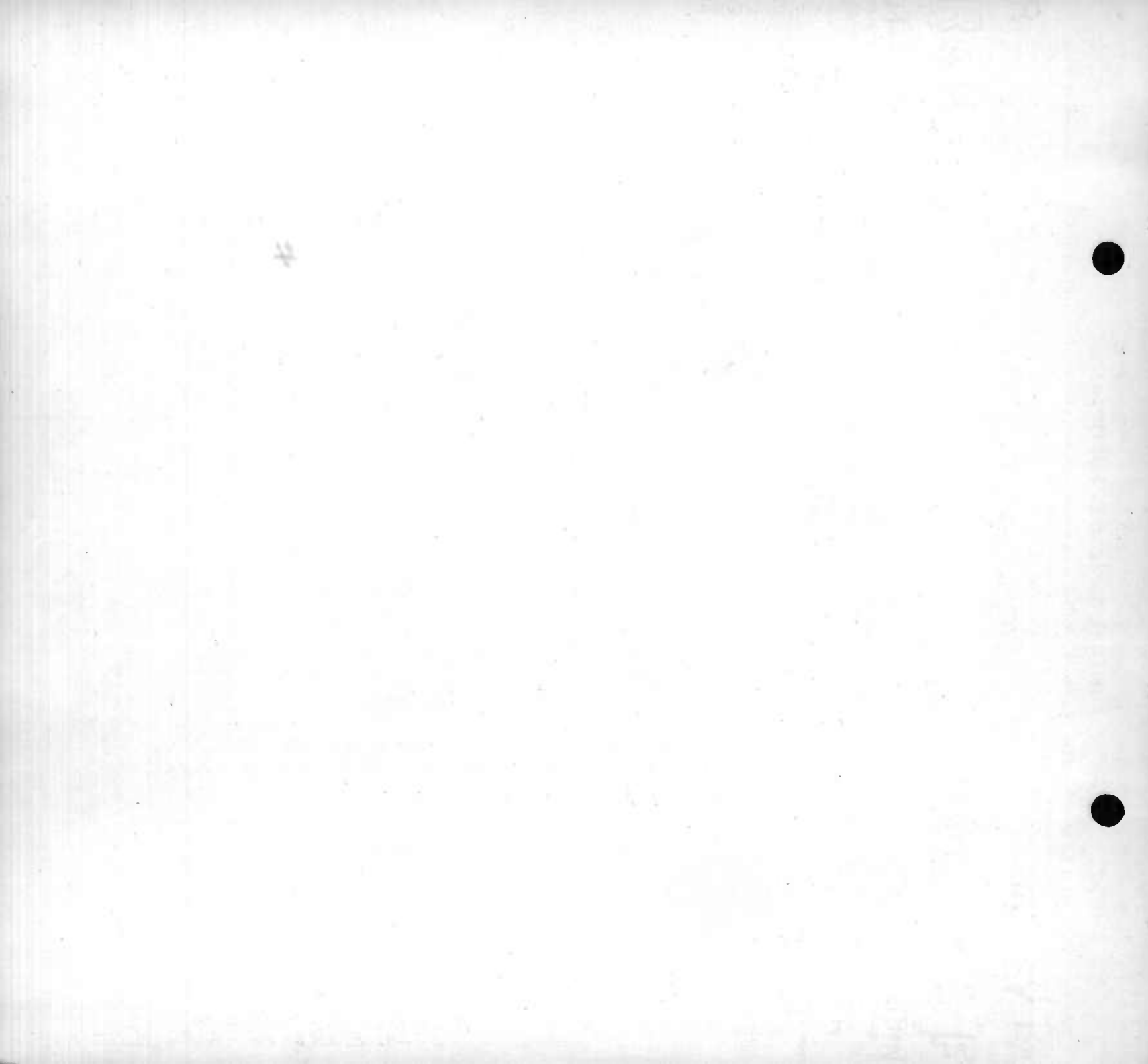
N-220

68- 6752

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68- 6752

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Louis MAKOS</i>		2. DATE AND HOUR OF DEATH <i>6-25-68 10:50 PM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		C. CITY OR TOWN <i>BALTIMORE</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>MARYLAND GENERAL HOSPITAL</i> <i>48</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-14-92</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>UNKNOWN</i>	
13. FATHER'S NAME <i>JAMES MAKON</i>		14. MOTHER'S MAIDEN NAME <i>STELLA ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO.</i>		16. SOCIAL SECURITY NO. <i>219-05-8266A</i>		17. INFORMANT <i>CHART.</i>	
18. <i>153.8</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Abdominal Carcinomatosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>primary in colon</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month.</i>	
153.8 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>6-25-68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>		20A. AUTOPSY? (Yes or No) <i>NO.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>B</u> (this hospital) attended the deceased from <u>5-19-68</u> 19 to <u>6-25-68</u> 19, that <u>A</u> (we) last saw the deceased alive on <u>6-25-68</u> 19 and that in <u>(us)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>U</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James F. Stooard MD</i>		23B. DATE SIGNED <i>6-25-68</i>		23C. PHYSICIAN'S NAME (Type) <i>JAMES F. STOOARD MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/28/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greek Orthodox Cem.</i>	
24D. LOCATION <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH/DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>	
25C. FUNERAL DIRECTOR <i>Nicholas J. Matthews</i>		25D. ADDRESS <i>3024 Eastern Ave, Baltimore, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6753	
A-600		68- 6753		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Robert J. Ayre</i>		2. DATE AND HOUR OF DEATH <i>June 28, 1968 11 30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>3612 Florida Road</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-27-1894</i>	9. AGE (In years lost birthday) <i>74-</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Patrolman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Franchiser College</i>		11. BIRTHPLACE (State or foreign country) <i>Scotland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Archibald Ayre</i>		14. MOTHER'S MAIDEN NAME <i>Flona Black.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES World War II</i>		16. SOCIAL SECURITY NO. <i>21512-0151A</i>		17. INFORMANT <i>Mrs. Beatrice M. Ayre</i> <i>3612 Florida Road</i>	
ADDRESS <i>Balto. Md 21207</i>					
18. <i>162.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>6/17</i> 19 <i>68</i> to <i>6/28</i> 19 <i>68</i> , that (I) was last saw the deceased alive on <i>6/28</i> 19 <i>68</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE <i>Paul Byers</i>		23B. DATE SIGNED <i>6/28/68</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto. National</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1968</i>		25B. NAME OF REGISTRAR <i>Robert J. Ayre</i>		25C. FUNERAL DIRECTOR <i>Paul Byers</i> <i>8428 Liberty Rd</i>	
ADDRESS <i>Randallstown</i>					

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "I have", "the", "and" are faintly visible.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6754	
B-255- 68- 6754				CERTIFICATE OF DEATH	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) GEORGE W. BOSMAN				6-26-68 9:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND. B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL Hospital				C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
BALTIMORE MD.				E. STREET AND NUMBER 8607 CHURCH LANE.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-03-01	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAB AIDE - CHEMIST				11. BIRTHPLACE (State or foreign country) MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY ?				12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Michael Bosman				14. MOTHER'S MAIDEN NAME BLAZEY - Ella Mae Clazey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 24-320-7-727	
17. INFORMANT CHART				ADDRESS	
18. 496X I S.S.#213-10-1721 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) fractured arm ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
493X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Post op cardiac arrest. (4-11-68)					
19A. DATE OF OPERATION 4-10-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED probable the heart and lungs		20A. AUTOPSY? (Y or N) (Y)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 8-29-68 19 to 6-26-68 19, that (A) (we) lost saw the deceased alive on 6-26-68 19 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James F. Stoddard MD				23B. DATE SIGNED 6-26-68	
23C. PHYSICIAN'S NAME (Type) JAMES F. STODDARD MD.				23D. ADDRESS Maryland General Hosp. Balt. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. STATE (State) Md.		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Loring Evers Funeral Home	
25D. ADDRESS 8728 Liberty Rd. Randallstown Md. 21133		25E. ADDRESS		25F. ADDRESS	

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 68- 6755			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) WILLIAM KERLER, Sr.						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 29-68 M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2320 W. Patapsco Ave.						3. DATE PRONOUNCED DEAD Month Day Year Hour June 29, 1968 6:35 A. M.					
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY											
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
9. DATE OF BIRTH July, 13, 1895		10. AGE (In years lost birthday) 72		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2320 W. Patapsco Ave.					
11. BIRTHPLACE (State or foreign country) Md				12. CITIZEN OF USA		13. FATHER'S NAME William F Kerler					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Kate Stolzenbach					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		18. INFORMANT Family		ADDRESS Same			
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.											
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6-29-68			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery				24D. LOCATION (City, town, or county) (State) Elkridge Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1968				25B. NAME OF REGISTRAR Robert E. Springate				25C. FUNERAL DIRECTOR ADDRESS McCully Funeral Home 237 Patapsco Avenue			

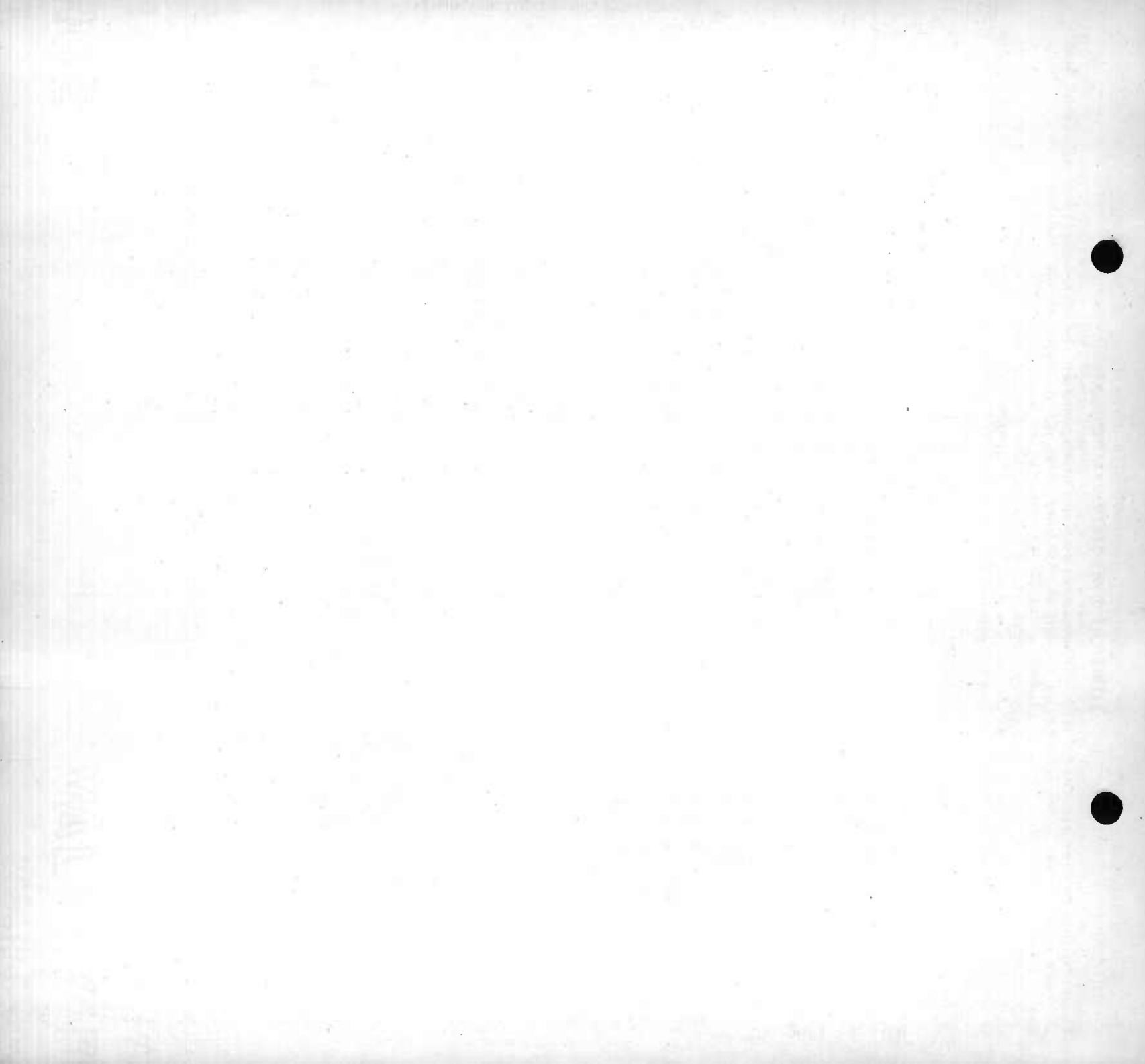
WALTER FORCE

Charles Light

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

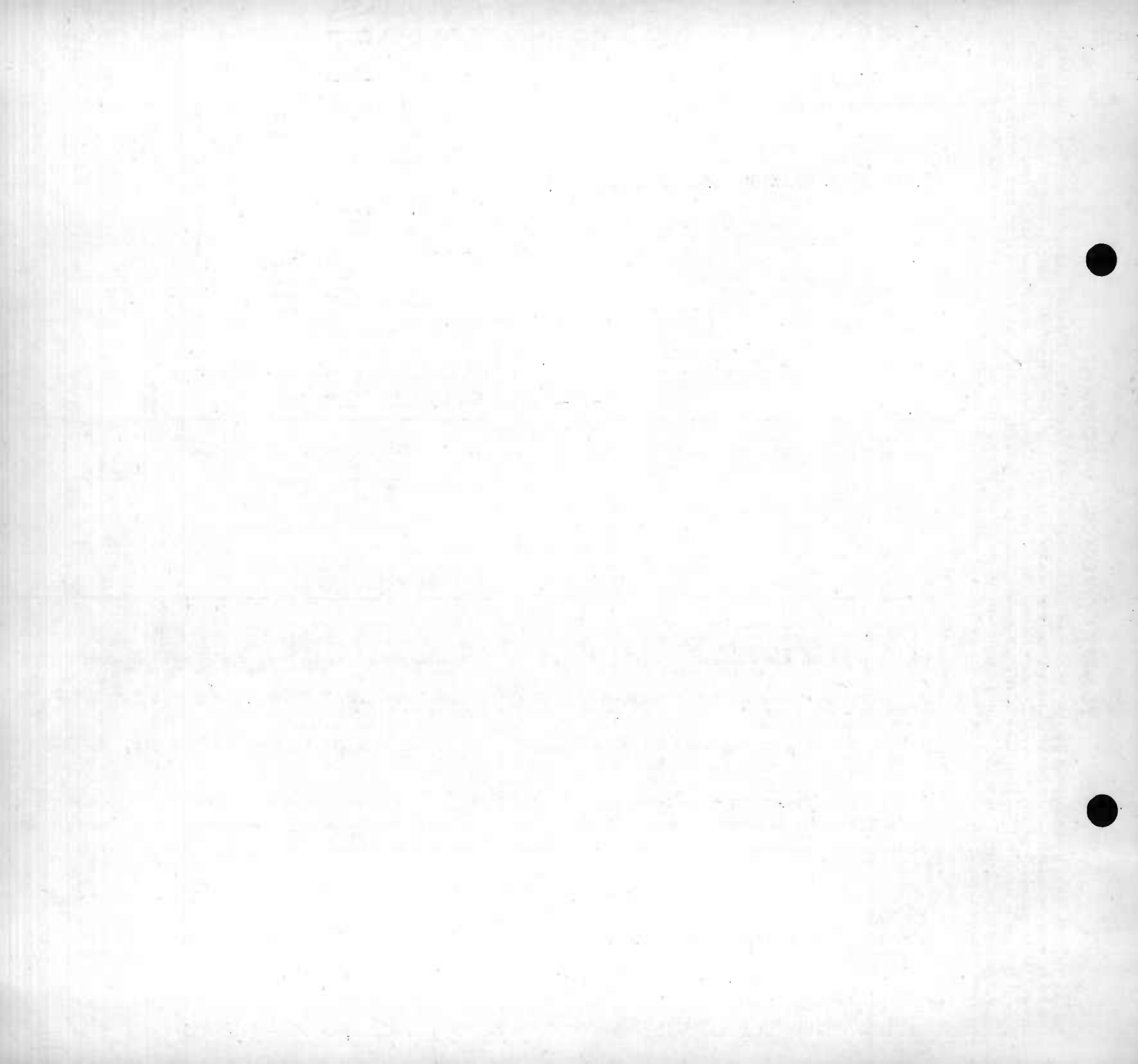
P-400		68- 6756		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6756	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Willie C. (William) Powell</u>				2. DATE AND HOUR OF DEATH <u>June 30 1968</u> 1 <u>0</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Maryland - Lombard & Green Sts. Baltimore, Md.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-3-12</u>	
9. AGE (in years last birthday) <u>55</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AUTOTIRE SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>HAIRYAY CO N.C.</u>	
13. FATHER'S NAME <u>Foster Powell</u>				14. MOTHER'S MAIDEN NAME <u>HATTIE WHITEHEAD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-14-9974</u>		17. INFORMANT <u>Virginia Powell</u>	
18. <u>431.9</u> I <u>1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Subarachnoid Hemorrhage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		ADDRESS <u>1303 WILLOWDALE AVE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>331X II</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3:00</u> to <u>3:00</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>30</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				23D. ADDRESS <u>[Address]</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>2/6/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore 21227</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Marshall [Signature]</u>		ADDRESS <u>638 N. [Address]</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

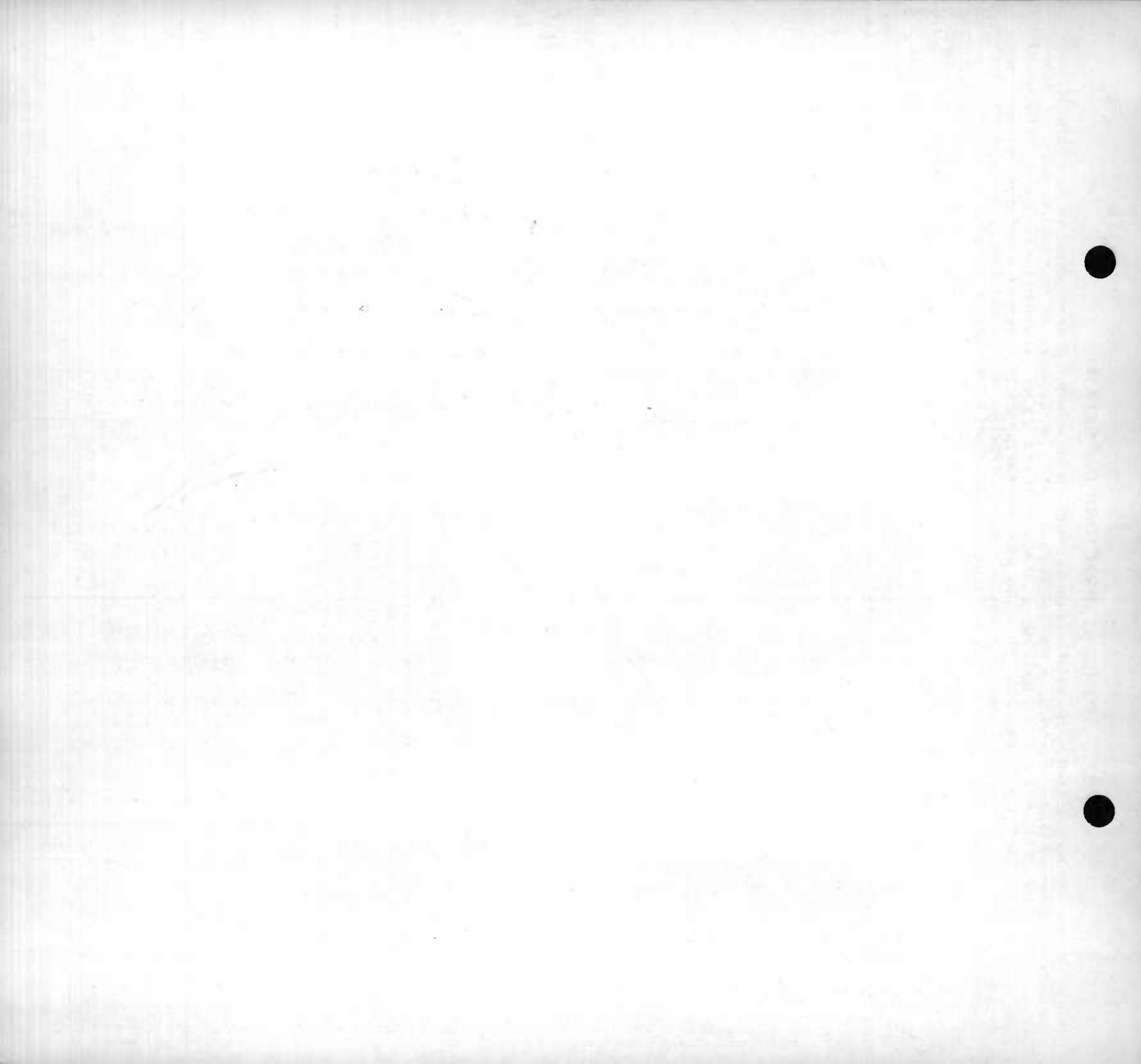
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6757	
<div style="display: flex; justify-content: space-between;"> L-200 68- 6757 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAGGIE A. LEACH		2. DATE AND HOUR OF DEATH 6-30-68 9:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON HILL NURSING AND CONVALESCENT CENTER 90			A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 16-00 E. STREET AND NUMBER 602 N. CLAYMONT AVE.		
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK			10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign Country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Bolton		
14. MOTHER'S MAIDEN NAME Julia			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 216-16-6837A			17. INFORMANT ADMISSION RECORD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF LUNG			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
MEDICAL CERTIFICATION 19. DATE OF OPERATION 163X II 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (the hospital) attended the deceased from May 20 19 68 to June 30 19 68 , that (we) last saw the deceased alive on June 30 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE H.C. Alevizatos, M.D.			23B. DATE SIGNED 30 June 68		
23C. PHYSICIAN'S NAME (Type) H.C. ALEVIZATOS, M.D.			23D. ADDRESS 1207 ST. Paul St, Balt, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burned	24B. DATE 7/3/68	24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Baltimore 21227		
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR James P. Hays ADDRESS 638 N. Gilmor			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6758	
BIRTH NO. R-200		68-6758		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>James T. Ross</i>			2. DATE AND HOUR OF DEATH <i>6-28-68</i> <i>12³⁰ P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN <i>BALTO</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>513 N GUMMERS ST</i>		
5. SEX <i>M.</i>	6. RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1900</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gen. Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>	11. BIRTHPLACE (State or foreign country) <i>Surry Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Ross</i>			14. MOTHER'S MAIDEN NAME <i>HONORABLE DAVIS</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-10-1231A</i>	17. INFORMANT ADDRESS <i>Alvin Gummer 1601 Laurens St</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <i>45-4 X II</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary Embolism acute MI</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Blood loss due to trauma Bladder tumor</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>JUNE 12</i> 19 <i>68</i> to <i>JUNE 28</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>JUNE 28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
26A. SIGNATURE <i>Bayani Phernalis M.D.</i>			23B. DATE SIGNED <i>6-28-68</i>		23C. PHYSICIAN'S NAME (Type) <i>BAYANI L. MANALO</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7/2/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbuthnot Park</i>
24D. LOCATION (City, town, or county) (State) <i>BALTO MD 21227</i>			25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1968</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR ADDRESS <i>Manoian D. Haynes 638 N GUMMERS ST</i>		



1

X-520 68-6759 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6759

BIRTH NO. 68-02603

1. NAME OF DECEASED (Type or Print) **ROBIN R. YOUNG**

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ **June 30, 1968** M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Bon Secours Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
June 30, 1968 1:20 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

6. SEX **Female** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH **Feb 3-1968** 10. AGE (In years lost birthday) **5** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) **BALTIMORE** 12. CITIZEN OF WHAT COUNTRY? **USA** 13. FATHER'S NAME **Francis Young Jr**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME **Jacqueline Briggs**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 17. SOCIAL SECURITY NO. **None** 18. INFORMANT ADDRESS **Jacqueline Young 24 N Bentalou St**

19. **795 X I** CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) IMMEDIATE CAUSE **Sudden death in infancy**
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:

20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) **Yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **June 30, 1968**
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7/6/68** 24C. NAME OF CEMETERY or CREMATORY **BALTO NATIONAL** 24D. LOCATION (City, town, or county) (State) **BALTIMORE**

25A. DATE REC'D BY HEALTH DEPT. **JUL 2 1968** 25B. NAME OF REGISTRAR **Robert E. Taylor** 25C. FUNERAL DIRECTOR ADDRESS **Thomas Sam P. Hays 68 N Grant St**

WALLEREN PROHIBIT

RE/MAY CONTINUT

Oct 17

1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH				3. DATE PRONOUNCED DEAD				4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
ROY KING				Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> June 28, 1968				June 28, 1968 1:00 P.M.				City Hospital (DOA)				A. STATE Maryland B. COUNTY			
6. SEX Male				7. RACE Negro				B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH May 24-1948				10. AGE (In years lost birthday) 1				If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.				E. STREET AND NUMBER 1900 W. Baltimore St.							
11. BIRTHPLACE (State or foreign country) BALTIMORE				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Ray Carpenter				14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME CAROLINE S. King				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				17. SOCIAL SECURITY NO. None				18. INFORMANT ADDRESS Caroline J. King 1900 W. Baltimore St							
19. 3590.1				CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				INTERVENTRICULAR SEPTAL DEFECT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Acute pyelonephritis with abscess formation											
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:															
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO, OR AS A CONSEQUENCE OF:															
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) Yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED				22F. HOW DID INJURY OCCUR?											
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6-29-68			
ACTUAL SIGNATURE Charles S. Springate M.D.				EXAMINER'S NAME (Type) Charles S. Springate, M.D.															
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 7/2/68				24C. NAME OF CEMETERY OR CREMATORY				24D. LOCATION (City, town or county) (State)							
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS							

RECEIVED

ALL 2-11-68

46-74-75 LB

W-426

68-6761

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 467475

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) WALKER, ATHY MAE		2. DATE AND HOUR OF DEATH 6/30 - 6:30pm	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.	
FULL NAME OF HOSPITAL OR INSTITUTION BALTO. CITY HOSP. 4940 EASTERN AVE., BALTO., MD. 21224		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITED YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE NEGRO	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/15	
9. AGE (In years lost birthday) 52		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME EDWARD FREEMAN	
14. MOTHER'S MAIDEN NAME LUCY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 226 484193		17. INFORMANT BALTO CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) SEPTICEMIA PULMONARY CARCINOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. +	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 163X II			
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19/68 to 6/30/68 , that (I) (we) last saw the deceased alive on 6/30/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE B. D. Snyder MD		23B. DATE SIGNED 6/30/68	
23C. PHYSICIAN'S NAME (Type) BRUCE D. SNYDER MD		23D. ADDRESS 4940 EASTERN AVE., BALTO., MD 21224	
24A. BURIAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY Transit-Burial 7-3-68 Denwitty Memorial Cemetery Petersburg, Va.		24D. LOCATION (City, town, or county) (State)	
25A. DATE RECD BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Salvo	
25C. FUNERAL DIRECTOR James A. Jackson		ADDRESS 20 Halefax St. Petersburg Va	

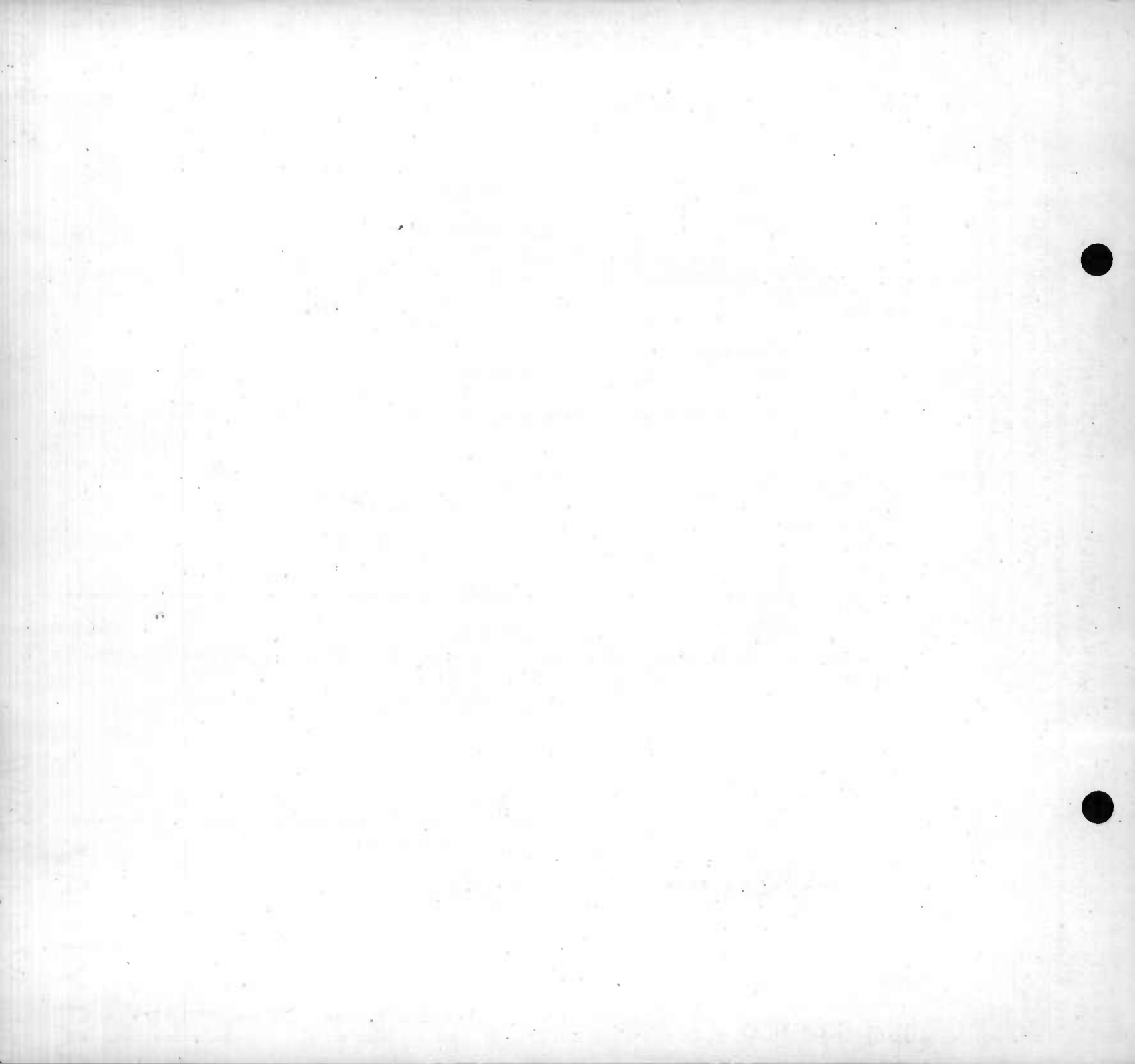
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

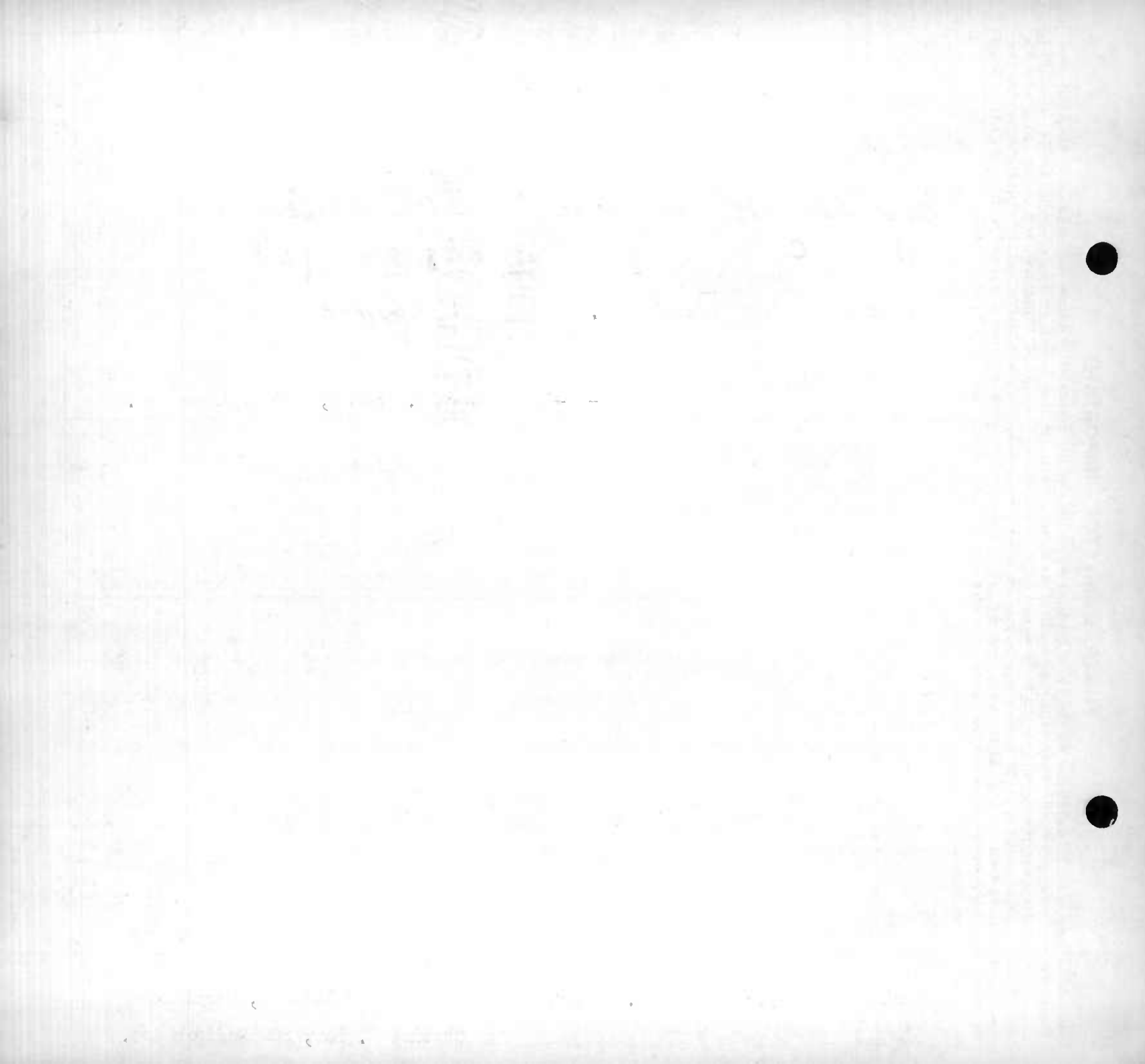
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6762	
<div style="display: flex; justify-content: space-between;"> J-250 68- 6762 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JACKSON, DAISY		2. DATE AND HOUR OF DEATH 6-27-68 11:00 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY Hospital			A. STATE Maryland B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 855 McALPHEE COURT		
5. SEX ♀	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME GEORGE GREEN		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Hospital chart		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pseudomonas CA OF OVARY					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Small bowel obstruction					
19A. DATE OF OPERATION 05-4-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel obstruction		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-6-68 19 to 6-27-68 19, that (1) (we) last saw the deceased alive on 6-27-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6-27-68	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-68		24C. NAME of CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968			
25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave,			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

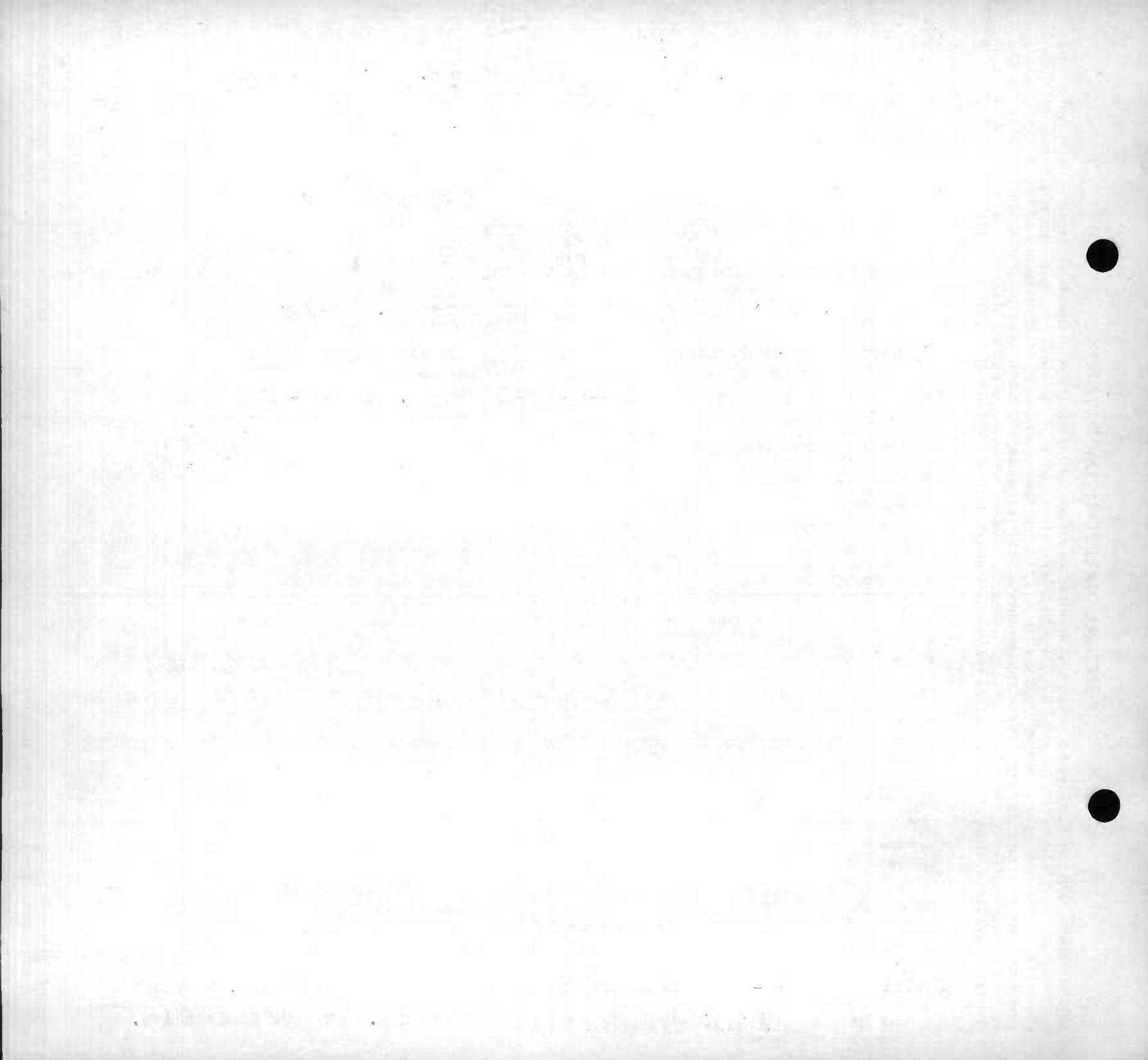
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6763
A-450		68- 6763 CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. BOLDEN ALLEN		
2. DATE AND HOUR OF DEATH June 28, 1968 10:15 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOW SECOURS HOSPITAL		
C. CITY OR TOWN BALTO. M.D.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 2400 HARLEM AVE		5. SEX M 6. RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 5/28/1900		9. AGE (In years lost birthday) 68		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY American Sugar Refining Co.		
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 218-03-8760		17. INFORMANT Cora M. Thomas, 2400 H arlem Ave.
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) cerebrovascular Accident weeks		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 27 19 68 to June 28 19 68 , that (I) (we) last saw the deceased alive on June 28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE DR. J. VILLARIN		23B. DATE SIGNED June 28/68		23C. PHYSICIAN'S NAME (Type) DR. J. VILLARIN
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6764</u>
5-303		68-6764		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Rutherford H. Strider</u>		2. DATE AND HOUR OF DEATH <u>6-30-68</u> <u>12:45 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>MD.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2703 Talbot Road</u>		
5. SEX <u>M</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-11</u>	9. AGE (In years last birthday) <u>57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Professor of Music</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Lexington, Kentucky</u>
13. FATHER'S NAME <u>Rutherford Hayes Strider</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Cooper</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>403-16-8329</u>		17. INFORMANT <u>Mary H. Strider - 2703 Talbot Road</u>
18. <u>420.1 II</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>420.1 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> <u>Accident</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6-23-68</u> to <u>6-30-68</u> and that (I) (we) last saw the deceased alive on <u>6-30-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Sam LeBeau</u>		23B. DATE SIGNED <u>6-30-68</u>		23C. PHYSICIAN'S NAME (Type) <u>Sam LeBeau</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u>		
25D. ADDRESS <u>802 Madison Ave.</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6765	
<div style="display: flex; justify-content: space-between;"> L-200 68- 6765 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Logue, Harry		2. DATE AND HOUR OF DEATH 6-26-1968 10:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Franklin Square Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 866 W. Baltimore, St.			
5. SEX Male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/18/91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-3191		17. INFORMANT Chart record	
18. 73671		CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) C. V. A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 0			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-18-1968 to 6-26-1968 , that (I) (we) last saw the deceased alive on 6-26-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6-26-1968	
23C. PHYSICIAN'S NAME (Type) J. Lee, M.D.		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/68		24C. NAME OF CEMETERY or CREMATORY St. Johns	
24D. LOCATION (City, town, or county) (State) Westminster, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968			
25B. NAME OF REGISTRAR Paul E. Chenoweth Jr.		25C. FUNERAL DIRECTOR Paul E. Chenoweth Jr. 3617 Chestnut Ave			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6766	
<div style="display: flex; justify-content: space-between;"> 6-165 68- 6766 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Doris C. Le Brun		6-26-68 10:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 110 Jeffery St.		
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1913	9. AGE (In years last birthday) 54 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Lein			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-9637		17. INFORMANT ADDRESS Mrs. Betty A. LeBrun 2159 Harman Ave. 21230	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from January 19 68 to 6/24 19 68 , that (I) (we) last saw the deceased alive on June 20 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. J. Gonce				23B. DATE SIGNED 6/27/68	
23C. PHYSICIAN'S NAME (Type) RICHARD LOZCHIT				23D. ADDRESS 1228 S. Ches St. Balto. Md 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 29, 1968		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy.	

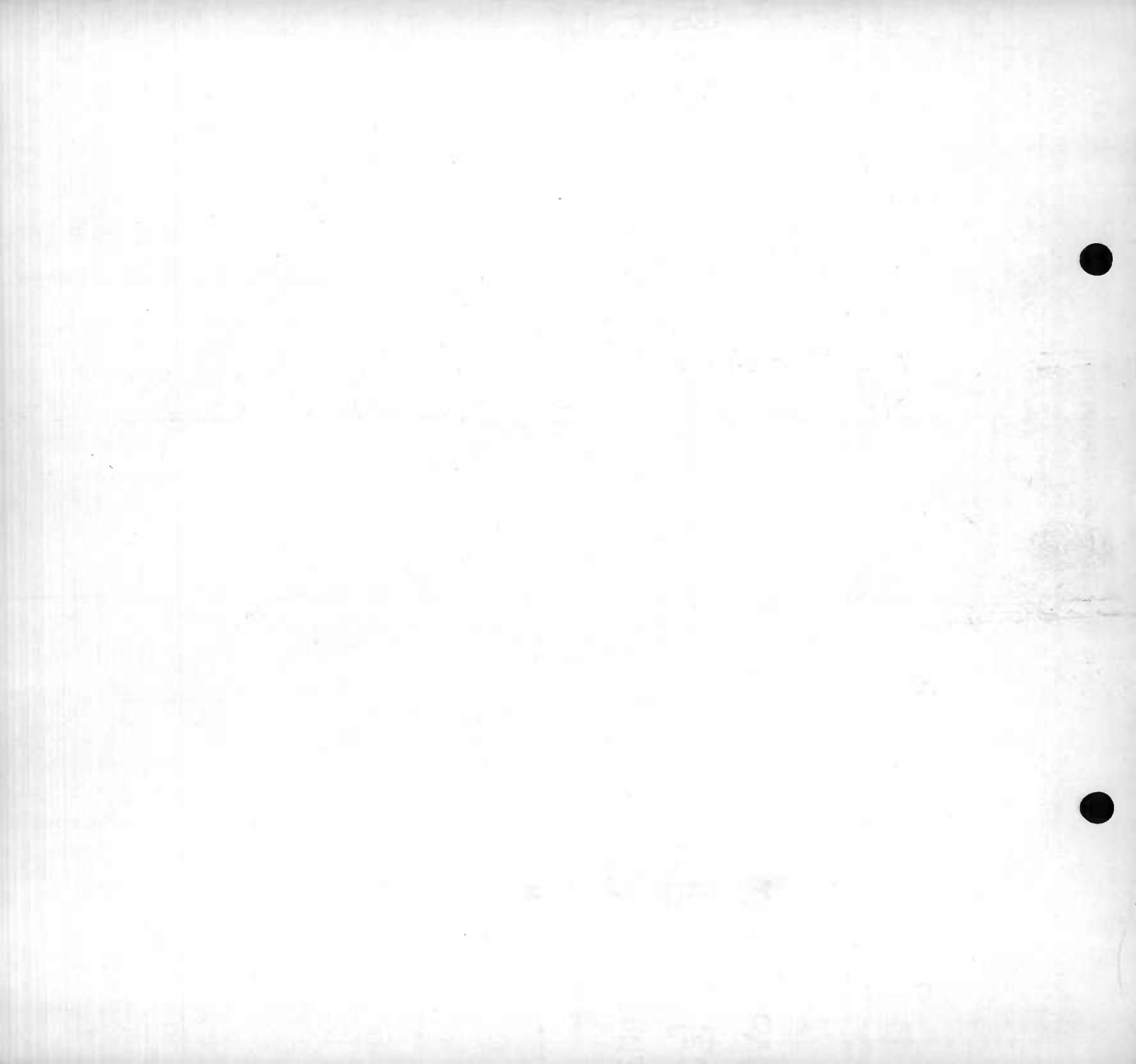
South Baltimore General Hosp. No. 1000
T. White

No.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-445 68-6767				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6767	
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) <u>Lillian M. Wilhelm</u>				2. DATE AND HOUR OF DEATH <u>6-30-68</u> <u>12:15 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>632 S. Decker Avenue</u>				A. STATE <u>Maryland</u>		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>632 S. Decker Avenue</u>							
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-94</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brent Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Theda Shipley</u>	
				ADDRESS <u>632 S. Decker Ave, Baltimore Md.</u>			
18. <u>175.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Caution of coronary metastasis to brain & heart.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
175.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> 19 <u>67</u> to <u>6/30</u> 19 <u>68</u> . that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joseph R. Liberto, M.D.</u>						23B. DATE SIGNED <u>7/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph R. Liberto, M.D.</u>						23D. ADDRESS <u>3508 Bank St., Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-68</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Nicholas J. Matthews</u>		ADDRESS <u>63021 Eastern Ave, Baltimore, Md.</u>	

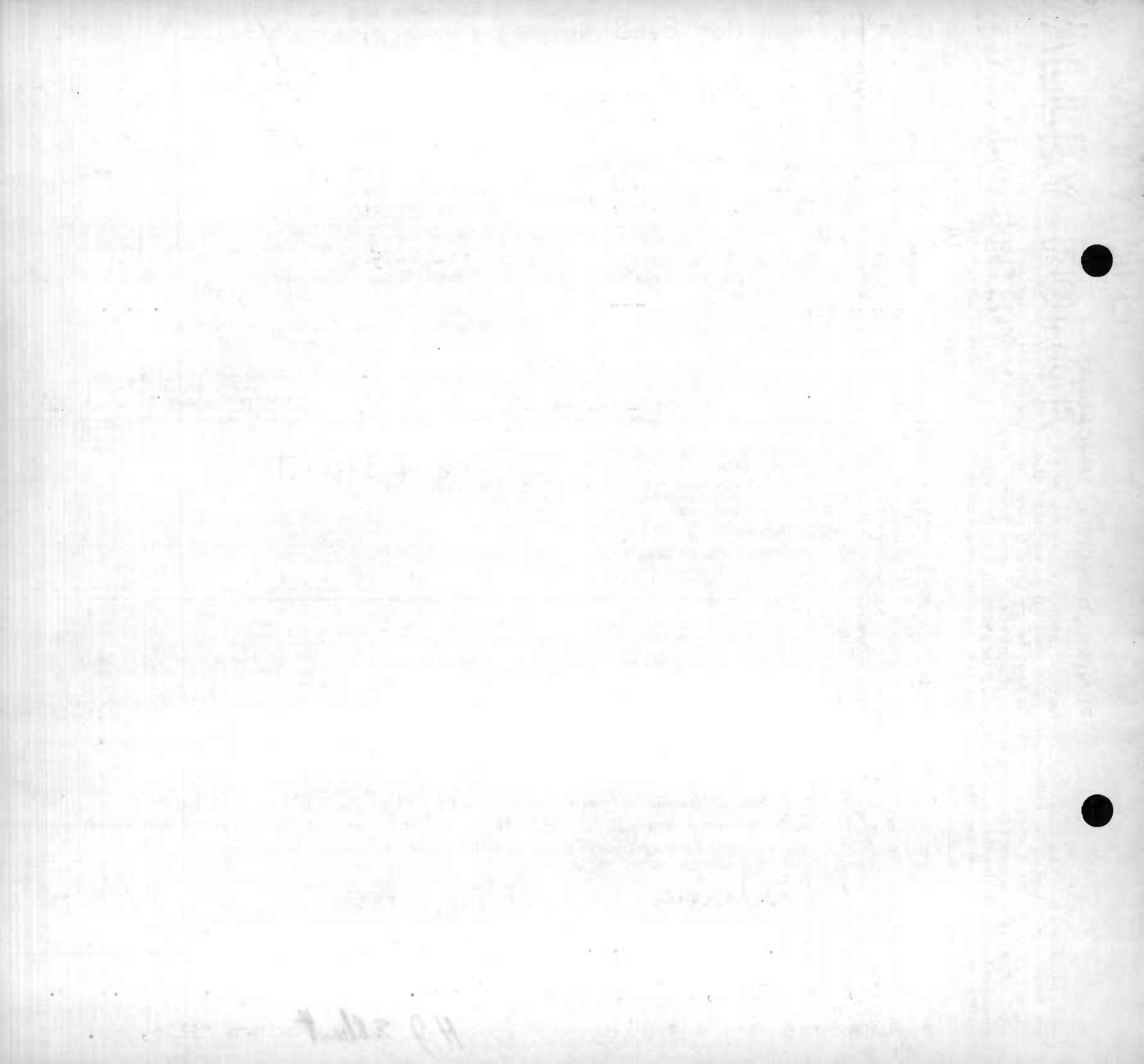


50-73-75 II

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-445				68-6768		68-6768	
1. NAME OF DECEASED (Type or Print) <i>Edith G. Wilhelms</i>				2. DATE AND HOUR OF DEATH <i>6/29/68 2:45 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>BALTIMORE, MARYLAND #21224</i>				A. STATE <i>MARYLAND</i> B. COUNTY <i>OWINGS MILLS</i> C. CITY OR TOWN <i>OWINGS MILLS</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <i>FEMALE</i>				6. RACE <i>WHITE</i>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>11-27-75</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				9. AGE (In years last birthday) <i>92</i>			
10B. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			
13. FATHER'S NAME <i>JESSE PHELAN</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				14. MOTHER'S MAIDEN NAME <i>BELLE BOWEN</i>			
16. SOCIAL SECURITY NO. <i>216-24-2694-D</i>				17. INFORMANT <i>BALTIMORE CITY HOSPITALS</i> <i>RECORDS 4940 EASTERN AVENUE # 21224</i>			
18. <i>174X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Ca of Breast</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <i>0</i>				20A. AUTOPSY? (Yes or No) <i>NO</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. HOW DID INJURY OCCUR?			
21F. HOW DID INJURY OCCUR?				21G. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/11 1967</i> to <i>6/29 1968</i> , that (I) (we) last saw the deceased alive on <i>6/29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>RE Tilmour</i>				23B. DATE SIGNED <i>6/29/68</i>			
23C. PHYSICIAN'S NAME (Type) <i>DR. TILMOUR M.D.</i>				23D. ADDRESS <i>BALTIMORE CITY HOSPITALS</i> <i>4940 EASTERN AVENUE</i> <i>#21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>July 1, 1968</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Park Cem.</i>				24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Balto., Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 - 1968</i>				25B. NAME OF REGISTRAR <i>R. E. E. E. E.</i>			
25C. FUNERAL DIRECTOR <i>H. J. Ehlhardt</i>				25D. ADDRESS <i>Owings Mills, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6769	
D-565		68- 6769		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Di Marino, Alfred E., Sr.		6/30/68 11 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND		BALTIMORE	
		E. STREET AND NUMBER		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		2034 EASTERN AVE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-1-13	54	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MACHINIST		MARTIN AIRCRAFT		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
ANTHONY DI MARINO		ELENA MANCINI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No.		218-36-4428		JOHN + ANGELA DI MARINO	
				ADDRESS 3118 FOSTER AVE. BALTO. MD. 21224	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		ASCVD			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(C) DUE TO, OR AS A CONSEQUENCE OF:			
422.1 II		Cirrrosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Years			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/24 1968 to 6/30 1968, that (I) (we) last saw the deceased alive on 6/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dudley D. Goulden				6/30/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DUDLEY D. GOULDEN		M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7-3-68	SACRED HEART OF JESUS		BALTO. COUNTY, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1968		Robert E. Fialkowski		W. FIALKOWSKI 2007 EASTERN AVE. BALTO. MD. 21231	

A2CND

Cirrhosis

1/20 1/20 1/20

1/20 1/20 1/20

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6770	
17-600 68-6770 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MURROW, JOHN R.		2. DATE AND HOUR OF DEATH 6/27/68 940 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balt Co			
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-2-25 9. AGE (In years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLASSIFIED MANAGER SUNPAPER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME GEORGE MURROW		14. MOTHER'S MAIDEN NAME EUNICE MURROW DAVIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 571.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE ACUTE CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF: (B) CIRRHOSIS OF LIVER DUE TO, OR AS A CONSEQUENCE OF: (C) GENERALIZED ANASARCA			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/26 19 68 to 6/27 19 68 , that (I) (we) last saw the deceased alive on 6/27 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. N. Kleiman		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DR. N. KLEIMAN (ATTENDING)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 68		24C. NAME OF CEMETERY or CREMATORY Greenwood	
24D. LOCATION (City, town, or county) (State) Howard County, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR John J. Corning		25D. ADDRESS 2402 Stonewall Court			

52-02-91 LB

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-200		68- 6771		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6771	
1. NAME OF DECEASED (Type or Print) PAUL SWIEC				2. DATE AND HOUR OF DEATH 6/29/68 8-29-68 5 305:30PM P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3205 ELLIOTT STREET 21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1916	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur			10B. KIND OF BUSINESS OR INDUSTRY Transfer Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Swiec			14. MOTHER'S MAIDEN NAME MARY KLUZA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -			16. SOCIAL SECURITY NO. 218 01 1619		17. INFORMANT ADDRESS RECORDS: BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224		
18. 39519 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE ? Ventricular tachycardia			
ANTECEDENT CAUSES				(B) Aortic stenosis & insufficiency			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CHF.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Rheumatic Fever in childhood.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/22 19 68 to 6/29 19 68, that (I) (we) last saw the deceased alive on 6/29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David Juan				23B. DATE SIGNED 6/29/68			
23C. PHYSICIAN'S NAME (Type) DAVID JUAN, M.D.				23D. ADDRESS 4940 EASTERN AVE., BALTO., MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR R. E. & J. Taylor		25C. FUNERAL DIRECTOR ADDRESS Brzezinski Funeral Home 1407 Eastern Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6772	
L-236 68- 6772		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BABY GIRL LASSITER		6-29-68		5.17 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
33 THE JOHNS HOPKINS HOSPITAL		MARYLAND		BALTIMORE CITY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. CITY OR TOWN		D. INSIDE CITY LIMITS?	
33 THE JOHNS HOPKINS HOSPITAL		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2244 PRENTISS PLACE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-27-68	--	2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
		JOSEPHINE LASSITER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 770.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Axial Membrane Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		761.5 II Prematurity. Abruptio Placenta			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27 19 68 to June 29 19 68 , that (I) (we) last saw the deceased alive on June 29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<input checked="" type="checkbox"/>) (did) (did not) view the body after death.					
23A. SIGNATURE Michael A. Simmons, M.D.				23B. DATE SIGNED 6/29/68	
23C. PHYSICIAN'S NAME (Type) MICHAEL A. SIMMONS				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Cremation		6/30/68		The Johns Hopkins Hospital	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1968		Robert E. Taylor		HOSPITAL DISPOSAL	

April 10, 1900

Received of the Treasurer

June 24, 1900

10

June 27, 1900

June 24, 1900

—

1900

14

10

Received of the Treasurer

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 68-6773

BIRTH NO. <u>68-6773</u>		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <u>Watkins, Carroll</u>		2. DATE AND HOUR OF DEATH <u>6-30-68</u> <u>3:40</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lincoln Memorial Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1346 Stockton St.</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-7-1899</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>68</u>
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Watkins</u>		14. MOTHER'S MAIDEN NAME <u>Florence Prior</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Walter Watkins 2564 Edmondson Ave.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 29</u> 19 <u>68</u> to <u>30 June</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>28 June</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Thomas Watkins</u>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Thomas Watkins</u>		23D. ADDRESS <u>5519 Edmondson Ave. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-3-68</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>	25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>	25C. FUNERAL DIRECTOR <u>V.R. Bailey</u>	ADDRESS <u>1348 N. Calhoun St</u>

TO: Mr. J. Edgar Hoover

RE: [REDACTED] 9-1-1938

Enclosed for the Bureau are

three copies of a letter

dated and captioned as above.

Very truly yours,

W. L. RORER
Special Agent in Charge

12-1-1938
[Signature]

[Signature]
[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6774	
BIRTH NO. 68-6774		1. NAME OF DECEASED (Type or Print) INGRAM, FRANK		2. DATE AND HOUR OF DEATH June 29, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSPITAL			A. STATE MARYLAND		B. COUNTY
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2029 BRUNT ST. 14-03		
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UTILITY MAN		10B. KIND OF BUSINESS OR INDUSTRY BALTIMORE GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME WILLIAM INGRAM		14. MOTHER'S MAIDEN NAME CORA LITTLE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-2942		17. INFORMANT Elver L. Ingram	
				ADDRESS same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 412.31			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE TERMINAL UREMIA DUE TO, OR AS A CONSEQUENCE OF:		
			(B) CHRONIC RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Arteriosclerotic heart disease & CHF.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7-20-0 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/27 1968 to 6/29 1968 , that (I) (we) last saw the deceased alive on 6/29/ 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) DR. PALAFAX	
		23D. ADDRESS NORTH CHARLES GEN. HOSPITAL		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-3-68	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Arbutus, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968	25B. NAME OF REGISTRAR Robert E. Fairman	25C. FUNERAL DIRECTOR V.R. Bailey		25D. ADDRESS 1348 N. Calhoun St.	

LEARN CHARTER (SEE REPORT) 22-11-1942

1-18-42

WILLIAM LUGAN

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

CHURCH

31-60-31 LB

68-6775

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

68-6775

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

PETER LASTER

2. DATE AND HOUR OF DEATH

6-30-68

3:55P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1209 N. GILMORE AVE. 21223

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2-18-01

9. AGE (In years
lost birthday)

67

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

WILLIAM

14. MOTHER'S MAIDEN NAME

LAURA

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

077106838

17. INFORMANT

ADDRESS
RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. 2122418. *410.9 + 1011.3*

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

*Myocardial infarction**18 hrs.*

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).*possible active TB**2 yrs.*

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At ☐Not White
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on

and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*E. M. Levinsohn, M.D.*Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

*6/30/68*23C. PHYSICIAN'S
NAME (Type)

E. M. LEVINSOHN, M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

7-3-68

Mt. Auburn Cemetery

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

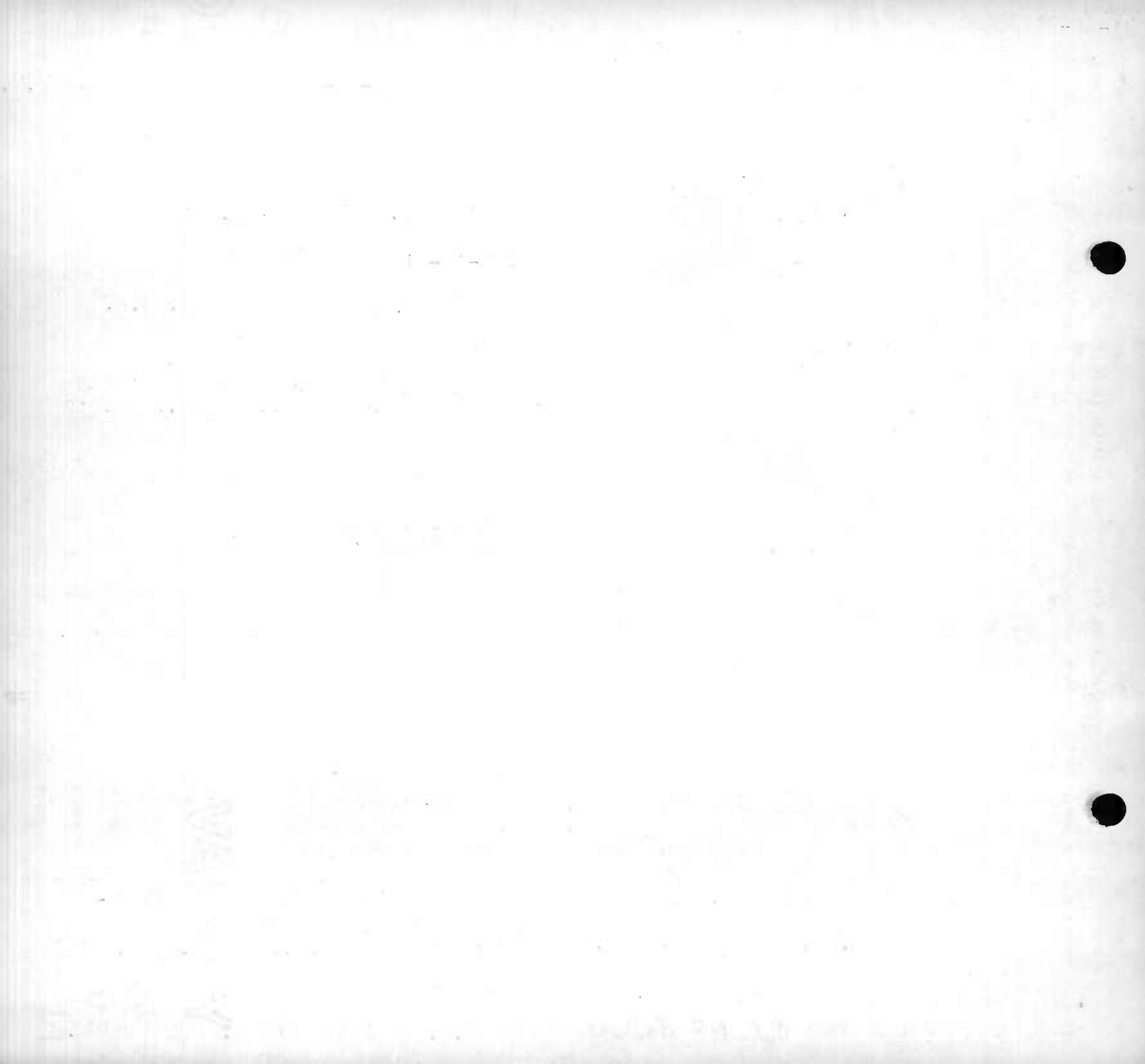
ADDRESS

JUL 2 1968 *Robert E. Fisher*

V.R. Bailey 1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

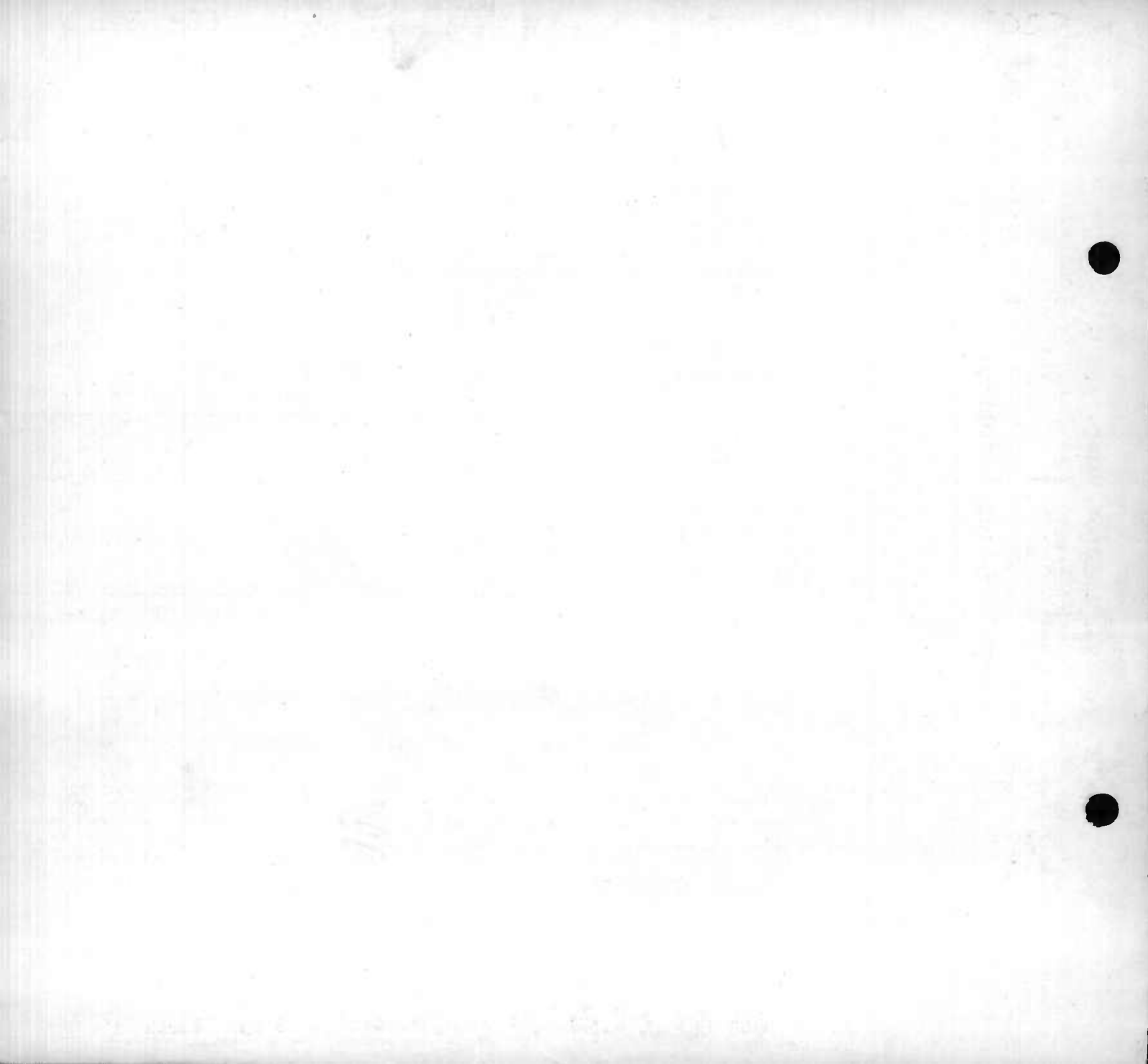
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6776	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Delores Bond</i>		2. DATE AND HOUR OF DEATH <i>6/28/68</i> <i>2:10 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9.9. Co. 52-00</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital</i>			C. CITY OR TOWN <i>Crownsville</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <i>Crownsville State Hospital</i>		
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/26/32</i>	9. AGE (In years last birthday) <i>36</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inmate</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>Benjamin Bond</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart at University Hospital</i>	
18. <i>008791</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Unknown</i> (A) IMMEDIATE CAUSE <i>upper GI Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>? Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Unknown etiology</i> (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9.6 hrs</i> <i>3.6 hrs. +</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>06-3.4 II</i>					
19A. DATE OF OPERATION <i>2 0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>0</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/27</i> 19 <i>68</i> to <i>6/28</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>B. Ann Ward, M.D.</i> DEGREE				23B. DATE SIGNED <i>6/28/68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/3/68</i>		24C. NAME of CEMETERY or CREMATORY <i>MT Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>A A County Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>A Halstead</i>	
				ADDRESS <i>1206 W North Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6777	
B-2351				68-6777	
1. NAME OF DECEASED BOSTON, ELIZABETH		2. DATE AND HOUR OF DEATH June 29, 1968 1:20 P.M.			
3. PLACE OF DEATH Baltimore, Maryland, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 16-06			
5. NAME OF HOSPITAL OR INSTITUTION 00 2925 W. Mosher Street Baltimore, Maryland		6. CITY OR TOWN Baltimore		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. SEX FEMALE 9. RACE NEGRO		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. DATE OF BIRTH 4/11/1870 12. AGE (In years last birthday) 98	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		14. KIND OF BUSINESS OR INDUSTRY		15. BIRTHPLACE (State or foreign country) Clarksburg, W. Va.	
16. FATHER'S NAME FREEMAN, WILLIAM		17. MOTHER'S MAIDEN NAME BRANDEN, ANNIE		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		20. SOCIAL SECURITY NO. 214/56/4745/jI		21. INFORMANT John H. Boston ADDRESS 2925 W. Mosher	
22. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 443X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0 20A. AUTOPSY? (Yes or No) 0 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 0 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 0 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 0 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 0 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 0		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years Years			
22. I certify that (I) (this hospital) attended the deceased from March 20 1968 to June 29 1968 , that (I) (we) last saw the deceased alive on May 28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucius W. Leeper		23B. DATE SIGNED July 1, 1968		23C. PHYSICIAN'S NAME (Type) Lucius W. Leeper	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Mt. Zion Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Morton & Dyett, 1701 Laurens St.	
26A. LOCATION Baltimore, Maryland		26B. ADDRESS Baltimore, Maryland			

1875

1875

1875

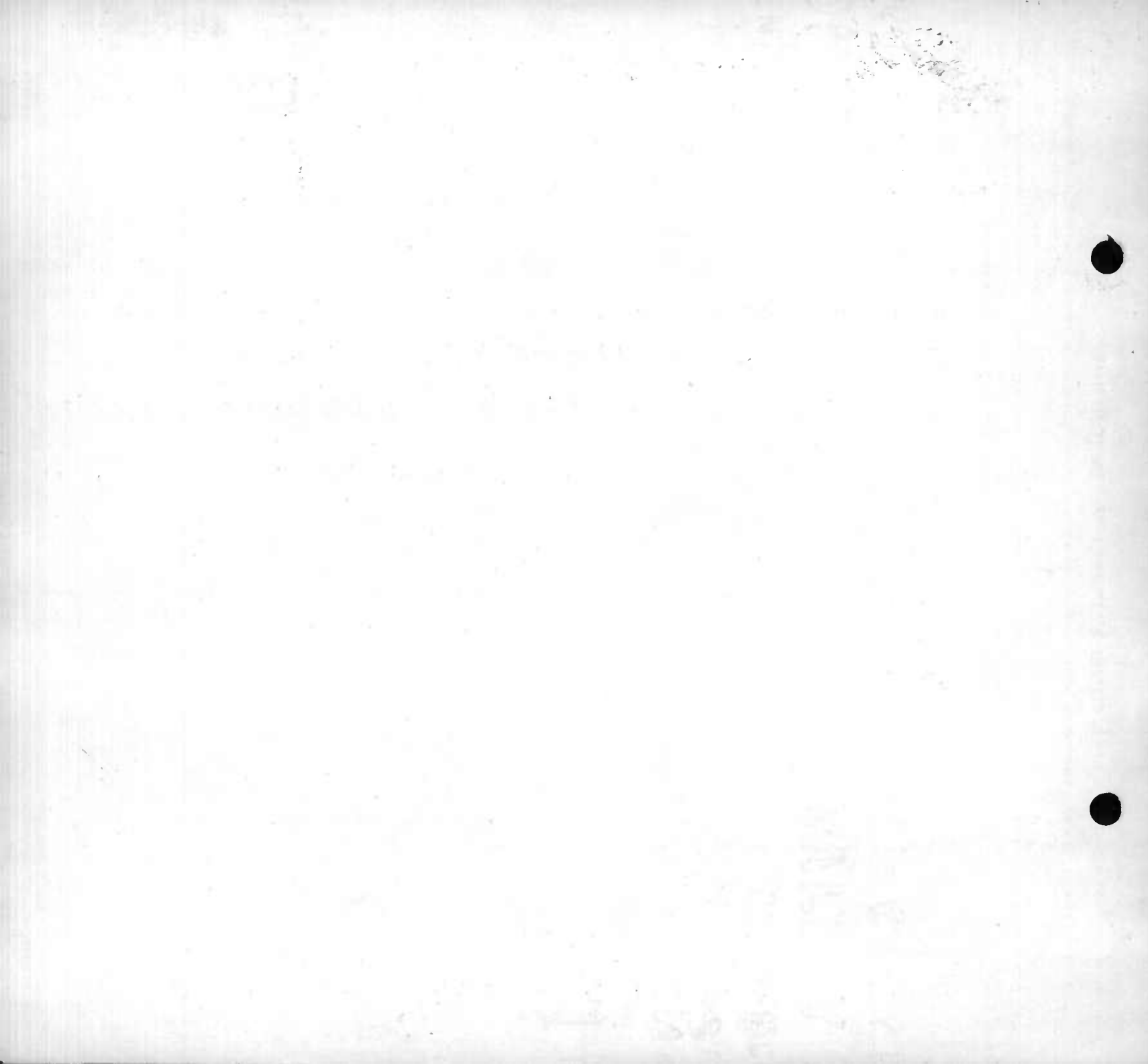
1875

1875

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

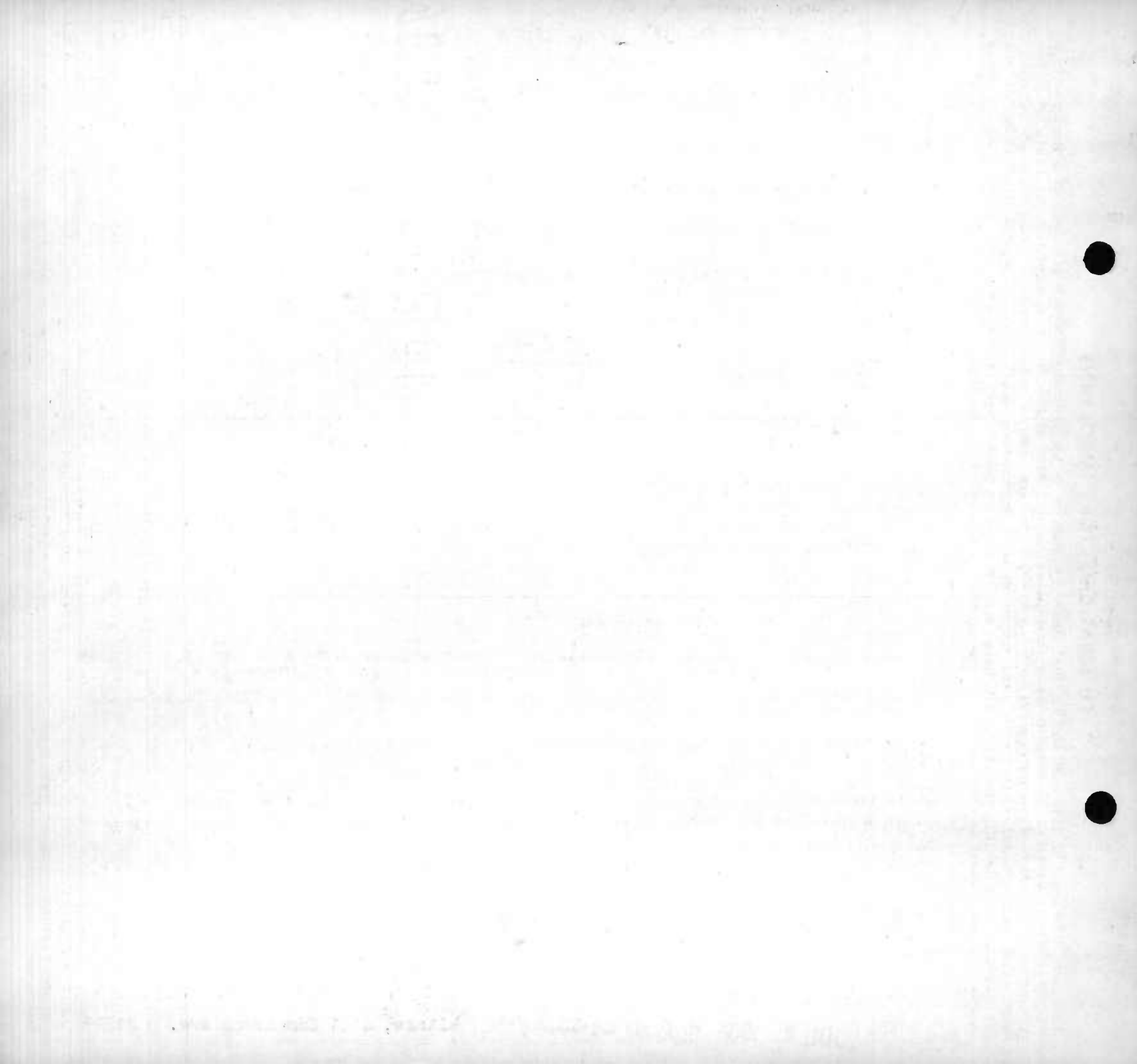
BALTIMORE CITY HEALTH DEPARTMENT			
CERTIFICATE OF DEATH			
BIRTH NO. 688-6778		688-6778	
1. NAME OF DECEASED BARRY WILLIE MAE BOWMAN		2. DATE AND HOUR OF DEATH 6/29/68 7:35 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD LUTHERAN HOSPITAL OF MD.		4. USUAL RESIDENCE (Where detailed living or institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-38	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD.		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE COLOURED		E. STREET AND NUMBER 2402 ROSLYN AVE.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/00 9. AGE (In years lost birthday) 68 YRS	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT WORK		11. BIRTHPLACE (State or foreign country) CREWE, VA	
10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME BAXTER BLAND		14. MOTHER'S MAIDEN NAME PATTY BLAND	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 24-18-381	
17. INFORMANT George DOWNING		ADDRESS 3105 BELMONT	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro Vascular Accident			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 331X II			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. HOW DID INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-29-68 19 to 6-29-68 19, that (we) last saw the deceased alive on 6-29-19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. P. JOSHI MD		23B. DATE SIGNED 6-29-68	
23C. PHYSICIAN'S NAME (Type) P. P. JOSHI MD		23D. ADDRESS 730 ASHBURTON ST. BALTO-16	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/68	
24C. NAME OF CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR James A. Perkins		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

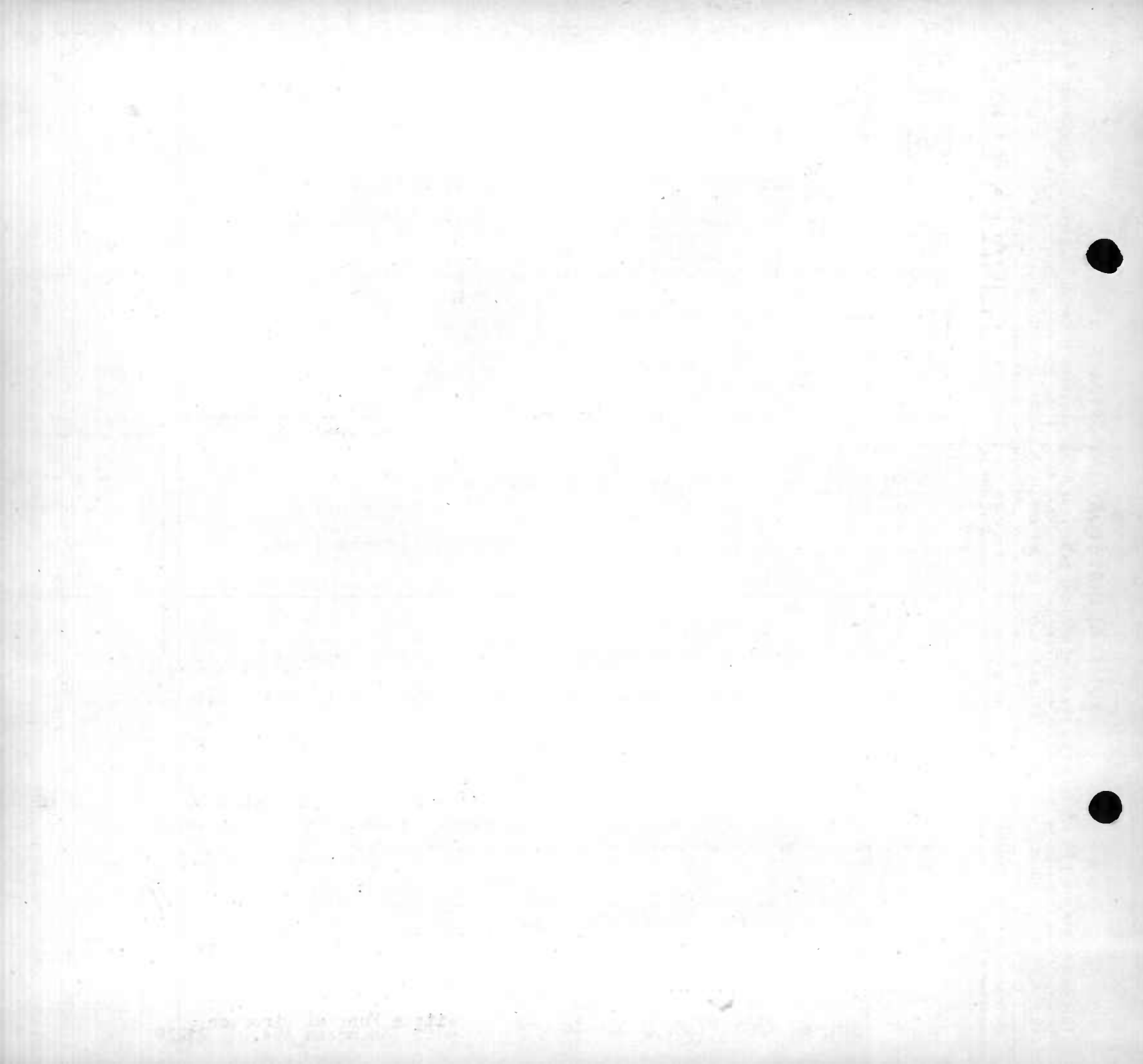
BIRTH NO. 68-6779		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6779	
1. NAME OF DECEASED (Type or Print) <i>Minnie Elizabeth Hutzler</i>		2. DATE AND HOUR OF DEATH <i>June 29, 1968 5:45 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>504 S. Gilmore St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/19/29</i>	9. AGE (In years last birthday) <i>39</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Dietrich Schmidt</i>		14. MOTHER'S MAIDEN NAME <i>Florine</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-54-0389</i>		17. INFORMANT <i>Albert G. Hutzler</i>	
18. <i>433.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>congestive heart failure</i> (C) _____			
19. <i>434.1 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 19 1968</i> to <i>June 29 1968</i> , that (I) (we) last saw the deceased alive on <i>5:45 P.M., June 29 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hyung Kon Lee, M.D.</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE, SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>Hyung Kon Lee, M.D.</i>		23D. ADDRESS <i>100 N. Calhoun St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Witake, 4101 Edmondson Ave. 21229</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT			
68- 6780		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 68- 6780	
1. NAME OF DECEASED (Type or Print) Irene Fitzsimmons		2. DATE AND HOUR OF DEATH June 30, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1715 Champlain Drive	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1925
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Hamlet West Apts.	9. AGE (In years last birthday) 42
11. BIRTHPLACE (State or foreign country) M		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Medvesky		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 194-20-8199	
17. INFORMANT Mr. James H. Fitzsimmons		ADDRESS 1715 Champlain Drive, 21207	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 398X Rheumatic Heart		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatic Heart (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 19 65 to June 24 19 68 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Milton Schlenoff		23B. DATE SIGNED 7/4/68	
23C. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff		23D. ADDRESS 6410 Windsor Mill Road, Balto., 21207	
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Burial July 13, 1967		24C. NAME OF CEMETERY or CREMATORY Crestlawn Cemetery, Marriottsville, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witka Funeral Director	
25D. ADDRESS 4101 Edmondson Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

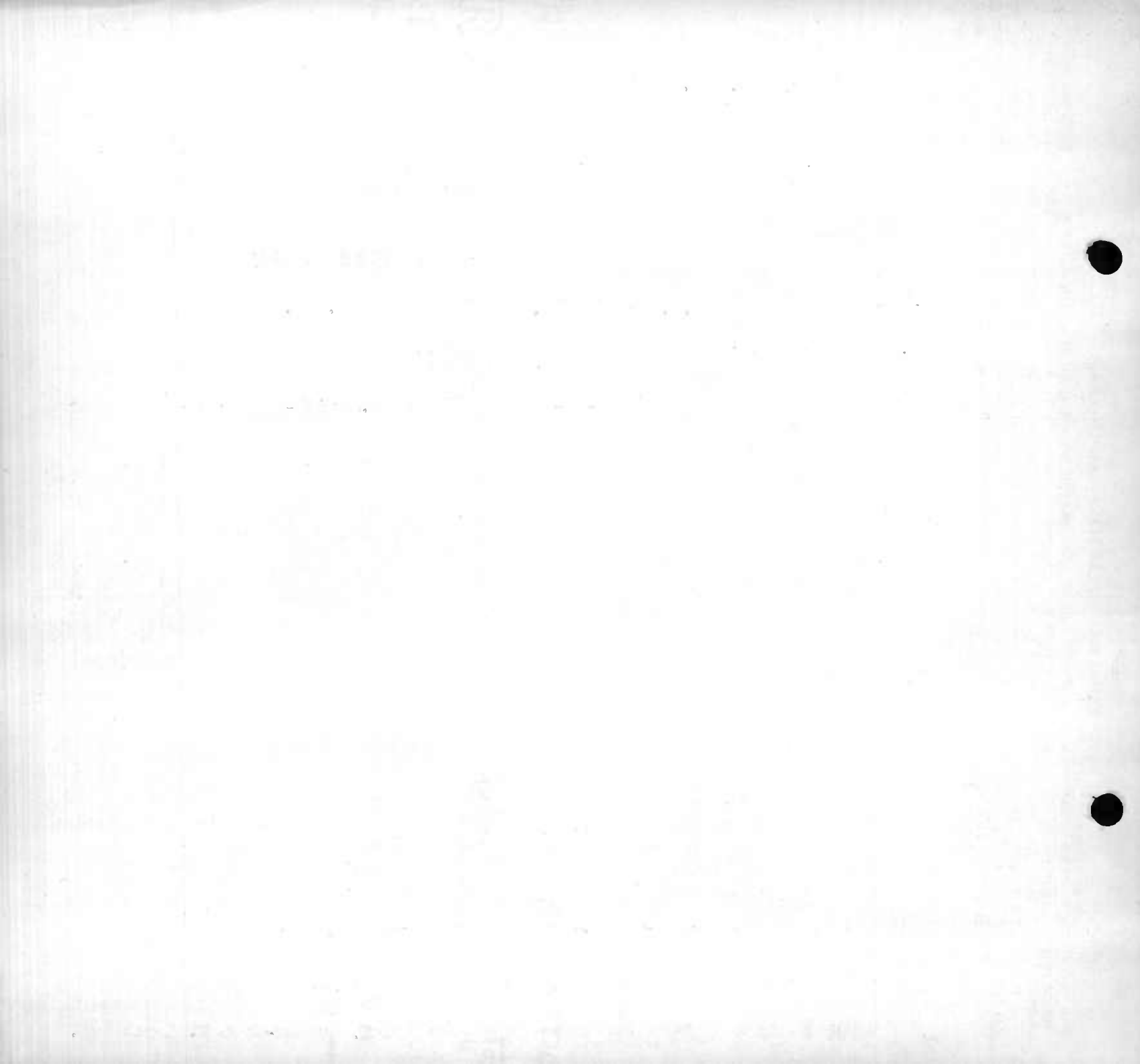
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-6781

68-6781

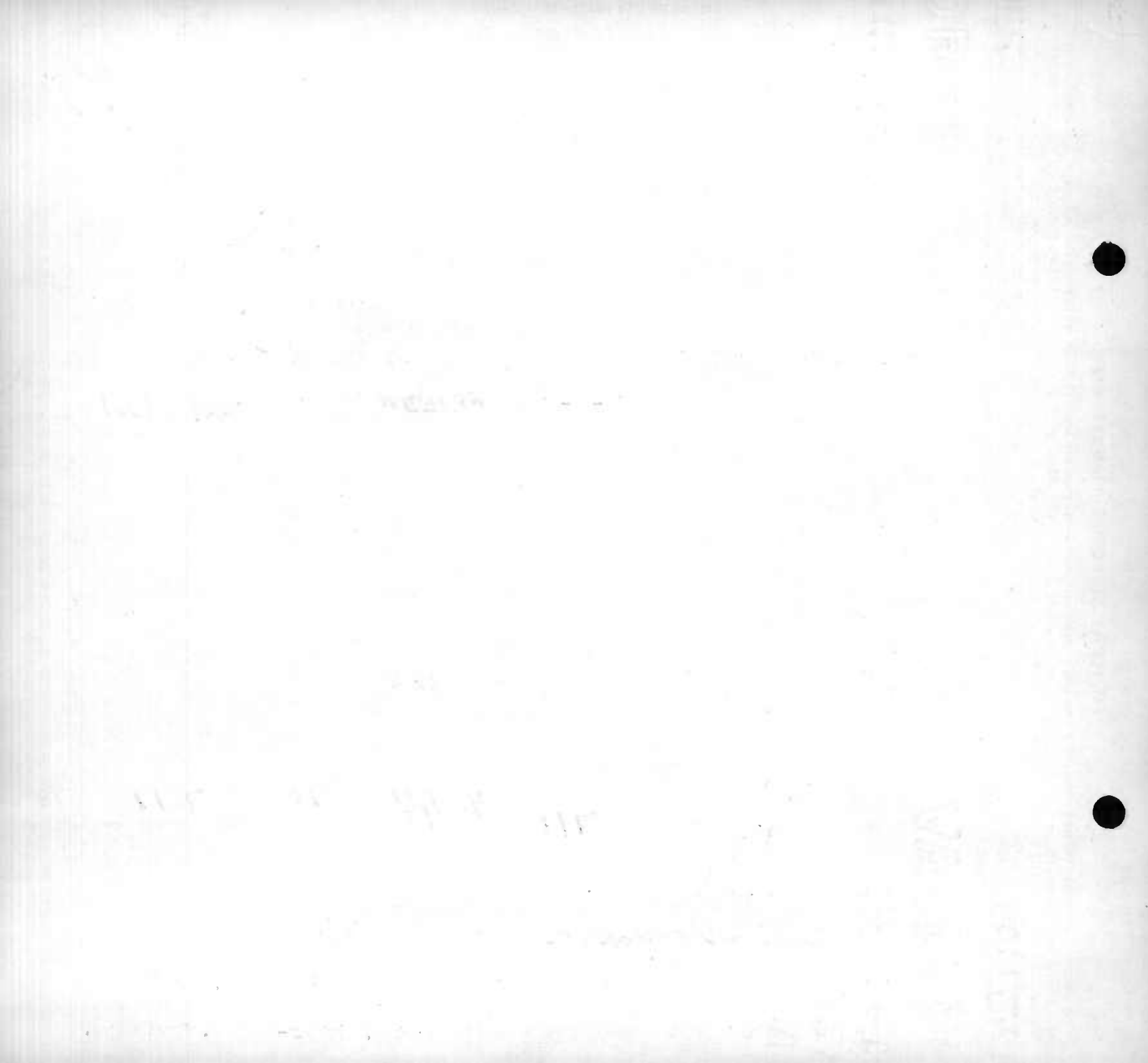
BIRTH NO.		1. NAME OF DECEASED (Type or Print) SMITH, M. GUSSIE		2. DATE AND HOUR OF DEATH 6-27-68 8-15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital 730, Ashburton St. Baltimore 21216			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md B. COUNTY 16-07 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3318, Brighton St.		
5. SEX F	6. RACE Coloured	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-4-1900	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY H.J. McGrath Co.		11. BIRTHPLACE (State or foreign country) Oberthrope Co. Ga.	
13. FATHER'S NAME Matthew Callahan			14. MOTHER'S MAIDEN NAME Nellie ? ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 260-14-		17. INFORMANT JOHN. M. Smith-3318 Brighton Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 427.3 I Septicemia.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Complete heart block (C)			1 day		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 433.0 II					
19A. DATE OF OPERATION 16-26-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED complete heart block		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6-21-1968 to 6-27-1968, that (X) (we) last saw the deceased alive on 6-27-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BIPIN DESAI				23B. DATE SIGNED 6-27-68	
23C. PHYSICIAN'S NAME (Type) BIPIN. DESAI M.D.				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/68		24C. NAME of CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION Laurel Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert E. Dutter-3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6782	
BIRTH NO. 68- 6782		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ESTHER HERTZFELD			2. DATE AND HOUR OF DEATH 7/1/68 2:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20-07		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 229 N. Culver Str.		
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/10/16	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY ADM.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Frank Lewis Hertzfeld			14. MOTHER'S MAIDEN NAME Margaret Elizabeth Bryant		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 213-20-5307		17. INFORMANT FRIEDA SPENCER	
				ADDRESS 229 N. Culver St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Ca Lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 + yr.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: + Intestine		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 199.2 II					
19A. DATE OF OPERATION 8		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/1/11 19 68 to 7/1 19 68 , that (I) (we) lost saw the deceased alive on 7/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samart Vechongsa M.D.				23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) SAMART VEOHONGSA				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert H. Nutter	
				ADDRESS 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6783</u>	
68- 6783					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Mr. Floyd Taylor</u>		2. DATE AND HOUR OF DEATH <u>July 1, 68</u> <u>10:20 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home & Hospital</u> <u>FAVETTE & BROADWAY</u> <u>BALTIMORE, MD. 21231</u>		C. CITY OR TOWN <u>BALTIMORE, MD.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking Lot Attend.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Parking Garage</u>		8. DATE OF BIRTH <u>11-23-11</u>	
13. FATHER'S NAME <u>George Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Rose Leidley Harris</u>		9. AGE (In years last birthday) <u>56 yrs.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-7024</u>		17. INFORMANT <u>Arthur Murray -2700 Allendale Road</u>	
18. <u>1978</u> I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<u>Terminal Carcinoma, Liver</u>		<u>Few Months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Religant Acids</u>		<u>Few months</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
15-6.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/30/1968</u> to <u>7/1/1968</u> , that (I) (we) last saw the deceased alive on <u>7/1/68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Krishna Reddy</u>				23B. DATE SIGNED <u>7/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>KRISHNA REDDY</u>				23D. ADDRESS <u>100N. Broadway, Balto. MD 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/6/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Herbert E. Nutter-3035 W. North Ave.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25D. ADDRESS <u>3035 W. North Ave.</u>			

George Taylor
M.D.
11-23-11
1900 U. Taylor M.D.
11-23-11
George Taylor
M.D.
11-23-11
1900 U. Taylor M.D.
11-23-11

1
P 620

68- 6784

BALTIMORE CITY HEALTH DEPARTMENT

68- 6784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) **SYLVIA PIERCE**

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ **June 28, 1968** M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Lutheran Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
June 28, 1968 8:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **15-06**

6. SEX **Female** 7. RACE **Negro** 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN **Baltimore** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **Oct. 24, 1960** 10. AGE (In years last birthday) **7** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER **2638 W. North Ave.**

11. BIRTHPLACE (State or foreign country) **Baltimore, Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Artis Holt**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Student** 14B. KIND OF BUSINESS OR INDUSTRY **School**

15. MOTHER'S MAIDEN NAME **Agnes M. Pierce**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO. **None** 18. INFORMANT **Agnes M. Pierce** ADDRESS **-2638 W. North Ave.**

19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)
Fracture of upper cervical spine
IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) **No**

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street** 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **North Ave. east of Braddish Ave.**

22D. TIME OF INJURY (APPROX.) **6-28-68 8:22 P.M.** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? **Pedestrian struck by car**

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE **Charles S. Springate, M.D.** CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **6-29-68**
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7/3/68** 24C. NAME OF CEMETERY or CREMATORY **Arbutus Memorial Park** 24D. LOCATION (City, town, or county) (State) **Baltimore Co. Maryland**

25A. DATE REC'D BY HEALTH DEPT. **JUL 2 1968** 25B. NAME OF REGISTRAR **Robert E. Fisher, M.D.** 25C. FUNERAL DIRECTOR **Herbert E. Nutter** ADDRESS **-3035 W. North Ave.**

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6785	
<div style="display: flex; justify-content: space-between;"> G-320 68- 6785 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED <small>(Type or Print)</small> GOODS, ALGLENN </div> <div> 2. DATE AND HOUR OF DEATH 7:30 AM 6/28/68 </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Maryland </div> <div> B. COUNTY Baltimore </div> </div> <div style="display: flex; justify-content: space-between;"> <div> C. CITY OR TOWN Baltimore </div> <div> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div> </div> <div> E. STREET AND NUMBER 409 N. Chester St. </div>		
5. SEX Male	6. RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/34	9. AGE (In years last birthday) 34	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter Goods			14. MOTHER'S MAIDEN NAME Vergie Saulkner		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES			16. SOCIAL SECURITY NO.	17. INFORMANT Vergie Goods Saulkner	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> CAUSE OF DEATH BACTERIAL PNEUMONIA + Sepsis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 493X II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/28/68 19 68 to 6/28 19 68 and that (I) (we) last saw the deceased alive on 6/28/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Reid				23B. DATE SIGNED 6/28/68	
23C. PHYSICIAN'S NAME (Type) Dr. Philip R. Reid				23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) 2-2-68		24B. DATE Burial		24C. NAME OF CEMETERY or CREMATORY Catholic Burial	
24D. LOCATION (City, town, or county) (State) Baltimore					
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Elroy D. Wilson	
				ADDRESS 2405	

July 1910

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES STAVIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year June 27, 1968		Hour 8:05 A.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year June 27, 1968		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 13, 1926		10. AGE (In years last birthday) 42		E. STREET AND NUMBER 736 Linnard Street			
11. BIRTHPLACE (State or foreign country) Cumtland Md		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Stavis		15. MOTHER'S MAIDEN NAME Maude Stavis	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes		17. SOCIAL SECURITY NO. 250-24-5200	
18. INFORMANT Myrtle Parker		ADDRESS 2341 W. Springdale St		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II							
20A. DATE OF OPERATION 4-22-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED June 27, 1968	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cat		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Elroy O. Shivers		ADDRESS 2401	

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101 57 100

VALLEY

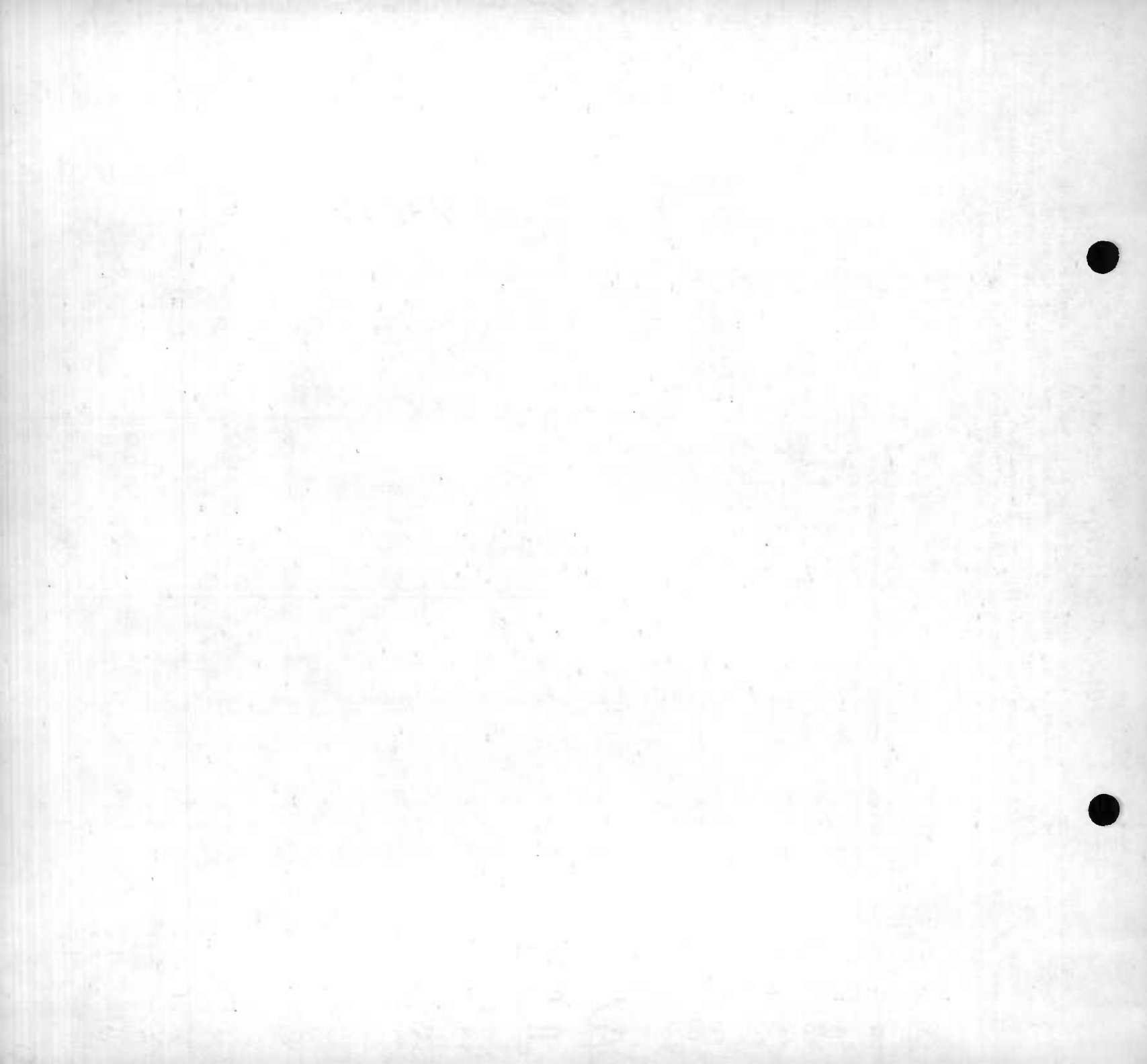
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6787	
H-463 68-6787		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Charles E. Willard</i>		2. DATE AND HOUR OF DEATH <i>6/29/68 8:40 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Prince Georges Co.</i> C. CITY OR TOWN <i>Laurel, Md.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>725 George St</i>			
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/14/12</i>	9. AGE (In years last birthday) <i>53</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Marjorie Reed</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>240-030117</i>		17. INFORMANT <i>Annie Willard</i> ADDRESS <i>725 George St</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i> <i>gangrene of leg</i> <i>UTM</i> (B) <i>Arteriosclerotic C-V. disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <i>36/5/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gangrene of leg</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/31/68</i> 19 to <i>6/29</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Martha Jane Tharpke, M.D.</i>		23B. DATE SIGNED <i>6/29/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Martha Jane Tharpke, M.D.</i>	
23D. ADDRESS <i>University Hospital 21201</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>7-3-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cmt</i>		24D. LOCATION (City, town or county) (State) <i>Baltimore</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Eloy O. Wilson</i> ADDRESS <i>sta 3</i>	



G-625-68-6788

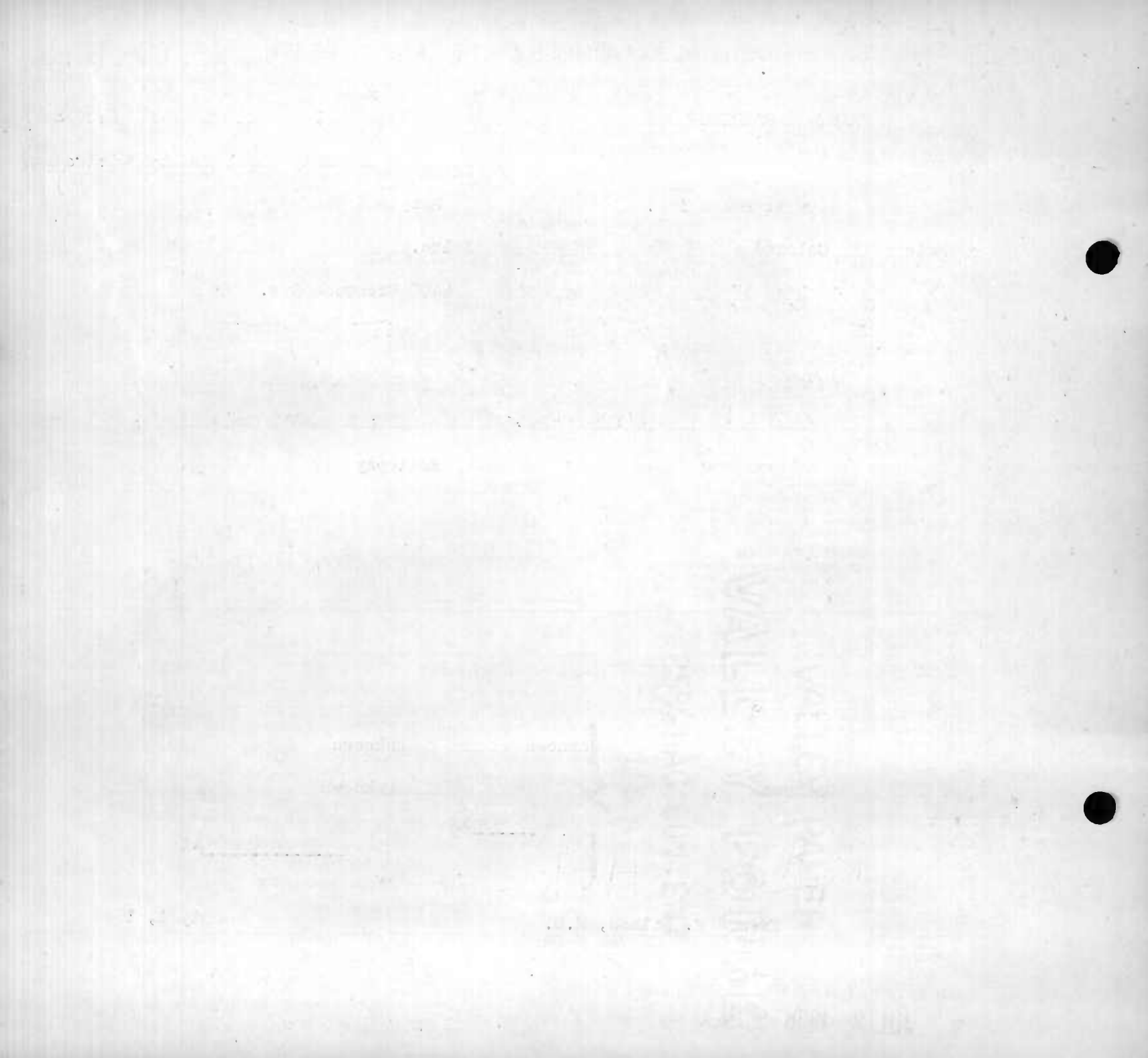
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6788

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GRANT GARRISON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 1 68 6:10 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4400 Wrenwood Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1 1968 6:10a M.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-10	
9. DATE OF BIRTH July 15 - 1929		10. AGE (In years last birthday) 38	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilmington Matheau		14. MOTHER'S MAIDEN NAME Lillian Lee	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) long		16. KIND OF BUSINESS OR INDUSTRY long	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		18. SOCIAL SECURITY NO. 220-20-2480	
19. 34597 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Epilepsy		20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
23. DATE OF OPERATION 7-5-68		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
25. AUTOPSY? (Yes or No) YES		26. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		28. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unknown	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Unknown		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> Unknown	
31. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		32. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
33. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		34. DATE SIGNED July 1, 1968	
35. BURIAL CREMATION, REMOVAL (Specify) Burial		36. DATE 7-5-68	
37. NAME OF CEMETERY or CREMATORY Balto		38. LOCATION (City, town, or county) (State) Balto MD	
39. DATE REC'D BY HEALTH DEPT. JUL 2 1968		40. NAME OF REGISTRAR Robert E. Tankey, M.D.	
41. FUNERAL DIRECTOR Gray Wilson 1000 Brantly rd		42. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 6-620		68- 6789		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) James Bowers		2. DATE AND HOUR OF DEATH 6-28-68 8:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Nursing Home		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3008 Barclay St			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 10-20-1898	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilmington Delaware	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-12-0981-A		17. INFORMANT Jean Brown 1840 1st Duham St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.9 I		CAUSE OF DEATH (A) DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		(B) DUE TO			
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12 1968 to 6-28 1968 , that (I) (we) last saw the deceased alive on 6-28 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 6-28-68	
23C. PHYSICIAN'S NAME (Type) Horne		23D. ADDRESS 5519 Kammern Av Pk 11, Sub			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 7-1-68		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cmt	
24D. LOCATION (City, town, or county) (State) Brooklyn Md		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Elmer C. Helms		25D. ADDRESS 1223			

Amos Memorial Hospital
Boston
308 Garden St

Mar 1940

11-2A

City of Boston
City of Boston

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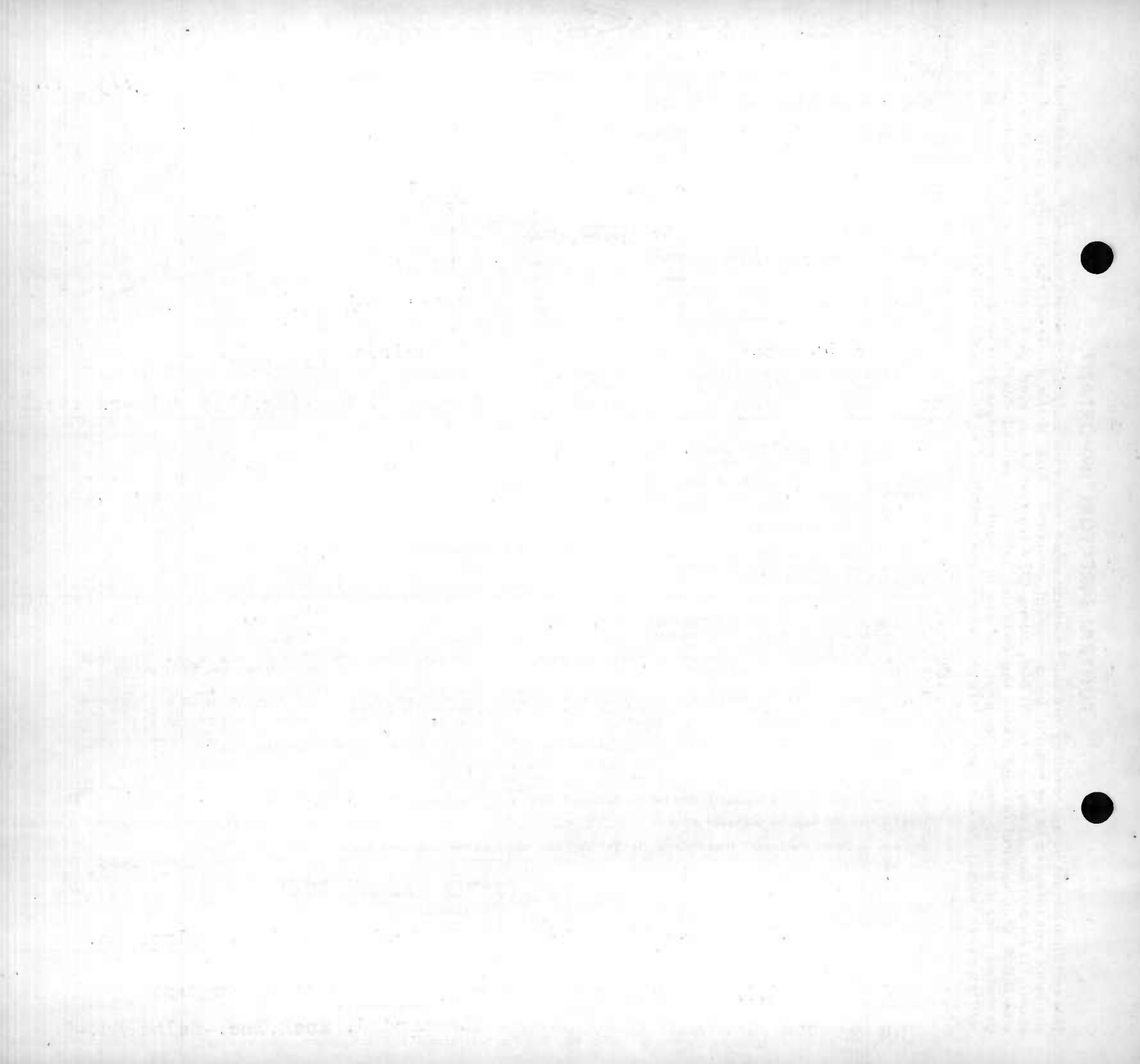
John J. [Signature]
John J. [Signature]

John J. [Signature]
John J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6790	
<div style="display: flex; justify-content: space-between;"> K-252 68-6790 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
GERTRUDE MAY REUSING		June 30, 1968		13:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1235 Walters Avenue...12			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1235 Walters Avenue...12		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
female	caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 24, 1905	62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife			Baltimore, Md.		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James Johnston			Lucinda Gerhouser		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
no			August P. Reusing, 1235 Walters Ave, 12		
18. 4 12 3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH arteriosclerotic heart disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 28 1966 to present 19 68 , that (I) (we) last saw the deceased alive on 6/28/68 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John Russell Davis				23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) Dr. John Russell Davis				23D. ADDRESS Medical Arts Bldg, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		7/3/68		Holy Redeemer Cemetery	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1968		Robert E. Taylor		Leonard J. Ruck, Inc.-Balto, Md.-14	



M-32468-6791

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6791

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELLA W. MITCHELL

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1625 Shadyside Rd. D.O.A.

6. SEX

Female

7. RACE
WhiteB. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

January 5, 1898

10. AGE (In years
lost birthday)
70If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?
USA14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife and Nurse

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.
None2. DATE
OF
DEATHKnown ☒
Estimated ☐Month
Day
Year

Hour

6

30

68

7:00 p

M.

3. DATE
PRONOUNCED DEAD

June

30

1968

7:00 p

M.

5. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1625 Shadyside Road

13. FATHER'S NAME

Robert Wade

15. MOTHER'S MAIDEN NAME

Mary Suttith

18. INFORMANT

ADDRESS

John Sommerville Atty. 1600 1st Nat'l. Bank

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Pulmonary emboli
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/3/68

24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1968

25B. NAME OF REGISTRAR

Robert E. Farkas

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck Inc. 5305 Harford Rd. 21214

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WILLIAM X. BROWN
JANUARY 1961

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-143		68-6792		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6792	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>							
1. NAME OF DECEASED (Type or Print) MARGARET M. SEBALD				2. DATE AND HOUR OF DEATH 7/1/68 8 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44. UNION MEMORIAL HOSP. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2806 HAMILTON AVENUE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02/7/1899	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Hartman Not				14. MOTHER'S MAIDEN NAME MARGARET HALLMEYER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. wa362227		17. INFORMANT MRS. PETER MESSINA ADDRESS 2827 BEECH-LAND AV.			
18. 3369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CUA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 337X II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>June 18</u> 19 <u>68</u> to <u>July 1</u> 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>July 1</u> 19 <u>68</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>did</u> (and not) view the body after death.							
23A. SIGNATURE Enrique Cipriani M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI M.D.				23D. ADDRESS 33rd + Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md.		ADDRESS 21214	

MARYLAND
 MARGARET
 MRS. PETER
 CVA
 HOSP. 2806 HAMILTON
 CO/D/12/12
 92
 F
 W
 X
 HOSP. WIFE
 NOT KNOWN

No

08 July 1968
 1/1/68
 X
 22 + Cabinet 24
 23
 24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 68- 6793			
<div style="display: flex; justify-content: space-between;"> P-360 68- 6793 CERTIFICATE OF DEATH </div>			
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) ANNA M. POTTER		2. DATE AND HOUR OF DEATH 30 JUN 68 3:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? 27-06 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2608 Gibbons Ave.	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1889 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Becker Pretzel Co.		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John G. Potter		14. MOTHER'S MAIDEN NAME Mary Metz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-22-2187	
		17. INFORMANT Marguerite C. Wolff same	
		ADDRESS	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 582X I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION	
		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: 4 YRS	
		(C) CHRONIC RENAL DISEASE 4 YRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 592X II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 23 JUN 19 68 to 30 JUN 19 68 , that (we) last saw the deceased alive on 30 JUN 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE Salvatore R. Donohue MD		23B. DATE SIGNED 18 JUL 68	
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE MD		23D. ADDRESS MERCY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		ADDRESS	

APR 11 1968

F W V

CHRONIC RENAL DISEASE
ASCUT
INFECTION
ACUTE MYOCARDIAL
DISEASE

30 JUN 68 23 JUN 68 20 JUN 68

✓ 18 JUL 68
JAWATORE R. DONOVAN MD
JAWATORE R. DONOVAN MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6794	
K-400 68- 6794				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dora B. Kelly		7/1/68 13:35 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GENERAL HOSPITAL			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 516 S. Hanover Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/91	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANK DYSON		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 27-407-1000		17. INFORMANT MRS DOROTHY MAYES 516 S. HANOVER ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 585X II		19. DATE OF OPERATION 3/19/68		20. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Fractured left hip		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/17/68 to 7/1/68, that (X) (we) last saw the deceased alive on 7/1/68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE A. Samadi, M.D.		23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) A. SAMADI, M.D.		23D. ADDRESS S.B.G.H. - 1213 Light Street			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/5/68	24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968	25B. NAME OF REGISTRAR Robert E. Jackson	25C. FUNERAL DIRECTOR McGilly		25D. ADDRESS 130 E. Fort Ave.	

PROPERTY OF THE

LIBRARY OF THE
CONGRESS

WASHINGTON, D. C.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6795	
1. NAME OF DECEASED (Type or Print) SANDERS, Walter NET B.				2. DATE AND HOUR OF DEATH 6-26-68 7:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1603 E. Baltimore, St.	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-21-13	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Salesman		10B. KIND OF BUSINESS OR INDUSTRY G & W Motors		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Harry Sanders			
14. MOTHER'S MAIDEN NAME Myrtle		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes 16. SOCIAL SECURITY NO. 4-26-43 to 10-26-43 220-07-07-14			
17. INFORMANT VA Hospital Records		ADDRESS 3900 Loch Raven Blvd, Baltimore, Md 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary tuberculosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probable coronary				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 1 month	
19A. DATE OF OPERATION 6-27-68					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 26, 1968 to June 26, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 26, 1968 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE DAVID N. MARINE, M.D.				23B. DATE SIGNED June 28, 1968	
23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-68		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION Baltimore, Maryland		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd.	
25D. ADDRESS					

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S-340 68- 6796 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68- 6796

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 30, 1968 M.	
ELLA R. SHETTLE		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1968 7:30 A. M.	
00 910 Mc Kewin Avenue		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		Maryland	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Female	White		Baltimore		
9. DATE OF BIRTH Dec. 11, 1880		10. AGE (In years last birthday) 87	E. STREET AND NUMBER 910 Mc Kewin Avenue		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Thomas S. Sinnott		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		14B. KIND OF BUSINESS OR INDUSTRY Retired	15. MOTHER'S MAIDEN NAME Martha Anderson		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213-05-8709	18. INFORMANT ADDRESS Mary D. Shettle (Daughter) Same		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: June 30, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/1968		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Eugenia K. Seitz		25D. ADDRESS 5209 York Rd.		Seitz Funeral Home Balto. Md. 21212	

VALLEY

Clare D. L. 74

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6797
BIRTH NO. 1. NAME OF DECEASED (Type or Print) McLean, GEORGE Y. <i>McLean, Baby Boy</i>		CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		2. DATE AND HOUR OF DEATH 6/30/68 5:40 P M. 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2914 ST. PAUL ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-68	9. AGE (In years last birthday) 4
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME GEORGE W. MCLEAN		14. MOTHER'S MAIDEN NAME CELESTE LEE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE <i>Hyaline Membrane Disease</i> DUE TO, OR AS A CONSEQUENCE OF: 4 days (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C)				
773.5 II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from JUNE 26 19 68 to JUNE 30, 19 68, that (1) (XX) last saw the deceased alive on JUNE 30 1968 and that in (my) (XX) opinion death occurred on the date and hour and from the causes stated above. (1) (XX) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Saul Roskes, M.D.</i> DEGREE				23B. DATE SIGNED 6/30/68
23C. PHYSICIAN'S NAME (Type) SAUL ROSKES, M.D. DEGREE				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hospital
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		
25B. NAME OF REGISTRAR <i>R. E. E. Johnson</i>		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		
ADDRESS				

XX

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XX

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-525		68-6798		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6798	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Agnes Virginia Benson			
2. DATE AND HOUR OF DEATH 6/26/68 7:00 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 East ern Ave. Baltimore, Maryland # 21224				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
8. DATE OF BIRTH 6-14-18		9. AGE (In years last birthday) 50		10. KIND OF BUSINESS OR INDUSTRY Office Clerk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Bloom		14. MOTHER'S MAIDEN NAME Winnefred		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --	
16. SOCIAL SECURITY NO. 220 07 5091		17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 416X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 6/26/68 19 to 6/26/68 19 that (I) (we) last saw the deceased alive on 6/26/68 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Francis P. Stange 23B. DATE SIGNED 6/26/68 23C. PHYSICIAN'S NAME (Type) Muelin G. Stange 23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. #21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 6/29/68 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968 25B. NAME OF REGISTRAR R. L. E. F. F. F. 25C. FUNERAL DIRECTOR Grudzinski Funeral Home 25D. ADDRESS 1407 Eastern Ave.			

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

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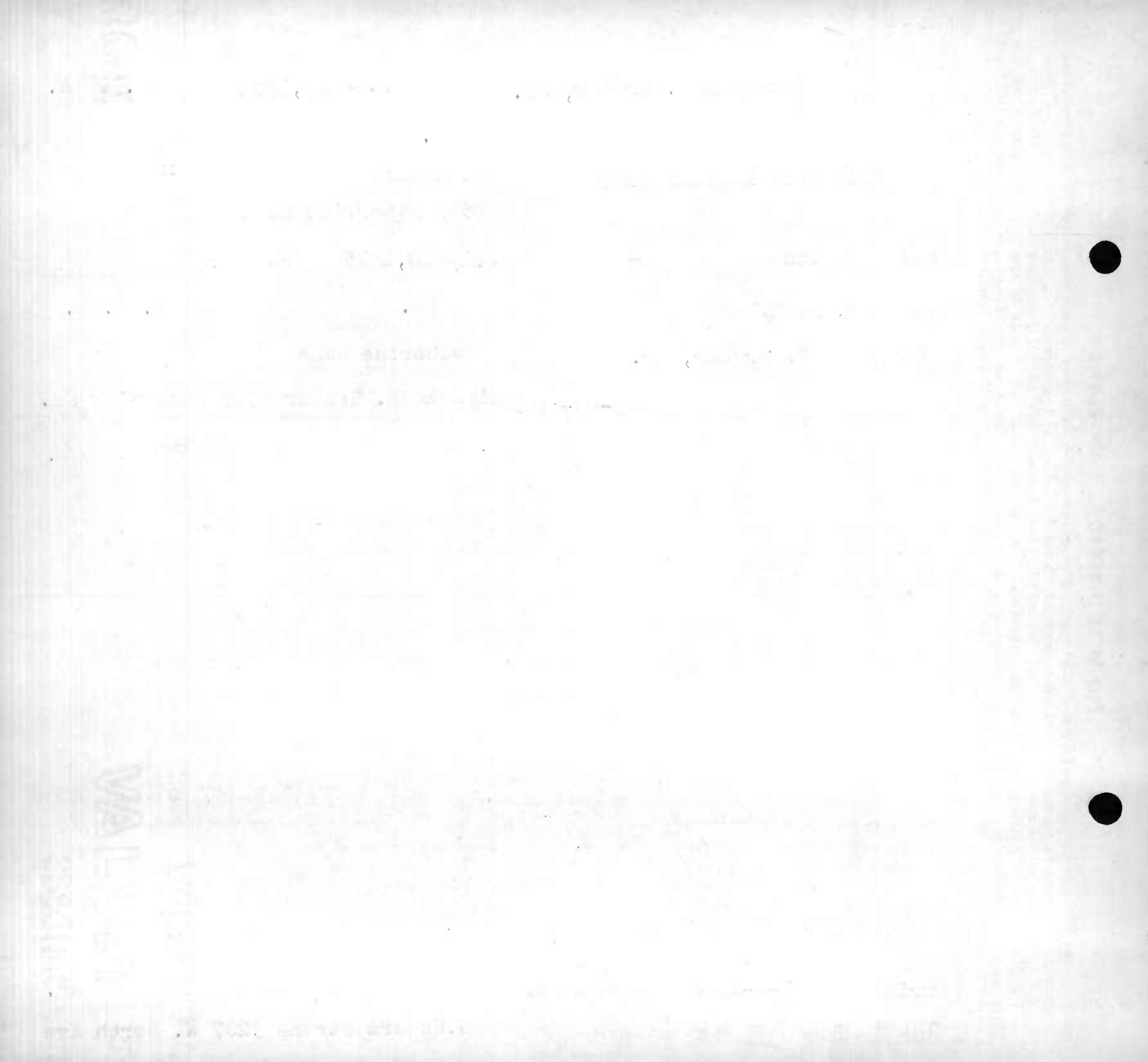
1951

CHICAGO, ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 88- 6789	
G-616 68- 6789 CERTIFICATE OF DEATH		BIRTH NO. 1. NAME OF DECEASED (Type or Print) Benjamin F. Gruber, Jr.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 Hood Convalescent Home		2. DATE AND HOUR OF DEATH June 29, 1968 6.30 A. M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hood Convalescent Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5. CITY OR TOWN Baltimore 6. STREET AND NUMBER 4503 Manorview Road			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Pattern Maker		10B. KIND OF BUSINESS OR INDUSTRY Wood Pattern Maker		8. DATE OF BIRTH July 20, 1875	
13. FATHER'S NAME Benjamin F. Gruber, Sr.		14. MOTHER'S MAIDEN NAME Catherine Hahn		9. AGE (In years lost birthday) 92 11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-8363		17. INFORMANT Rignald R. Gruber	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.47-185X Cerebrovascular accident		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD with congestive failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 422.1 II Coronary artery disease		(B) DUE TO, OR AS A CONSEQUENCE OF: failure		1 yr	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II Coronary artery disease		(C) DUE TO, OR AS A CONSEQUENCE OF: failure		1 yr	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 29 June 1968 to 29 June 1968 , that (I) (we) last saw the deceased alive on 29 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James E. Rowe MD				23B. DATE SIGNED 6/29/68	
23C. PHYSICIAN'S NAME (Type) JAMES E. ROWE MD				23D. ADDRESS 5550 BALTO. NATL PIKE 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR G. Howard Strong	
25D. LOCATION (City, town, or county) Baltimore		25E. ADDRESS (State) Md.			



FUNERAL DIRECTOR: IMPORTANT

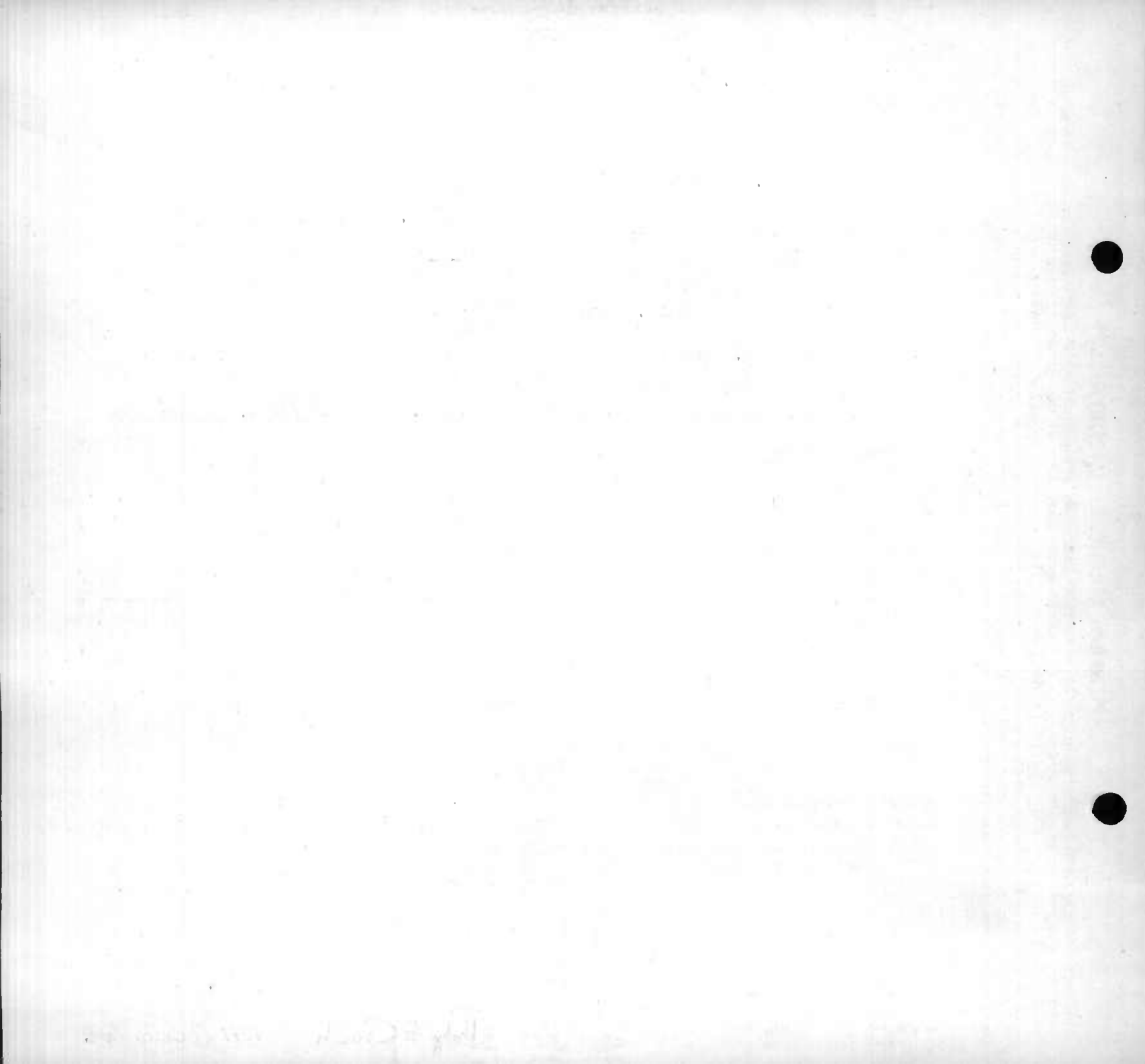
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6800</u>	
<u>S-152</u> <u>68- 6800</u> CERTIFICATE OF DEATH					
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MARY JANE SAPPINGTON</u>				6/28/68 7 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>	
<u>1444 COVINGTON ST.</u>				C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday) <u>1/24/84</u> 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. BLANCHARD</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA SHELBY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.	
17. INFORMANT <u>David Sappington 647 Riverside Dr.</u>				ADDRESS	
18. <u>1517 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				<u>Circinoma Stomach 6 mo.</u>	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:	
151X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>16-12-68</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca Stomach</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/3/68</u> 19 to <u>6/28/</u> 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>6/28/</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Emanuel S. Ellison M.D.</u>				23B. DATE SIGNED <u>7/1/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>Emanuel S. Ellison</u>				23D. ADDRESS <u>107 E. West Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/2/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION <u>Glen Burnie</u>		24E. (City, town, or county) <u>AA</u>		24F. (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>McCully Baltimore-Md.</u>	

FUNERAL DIRECTOR: IMPORTANT

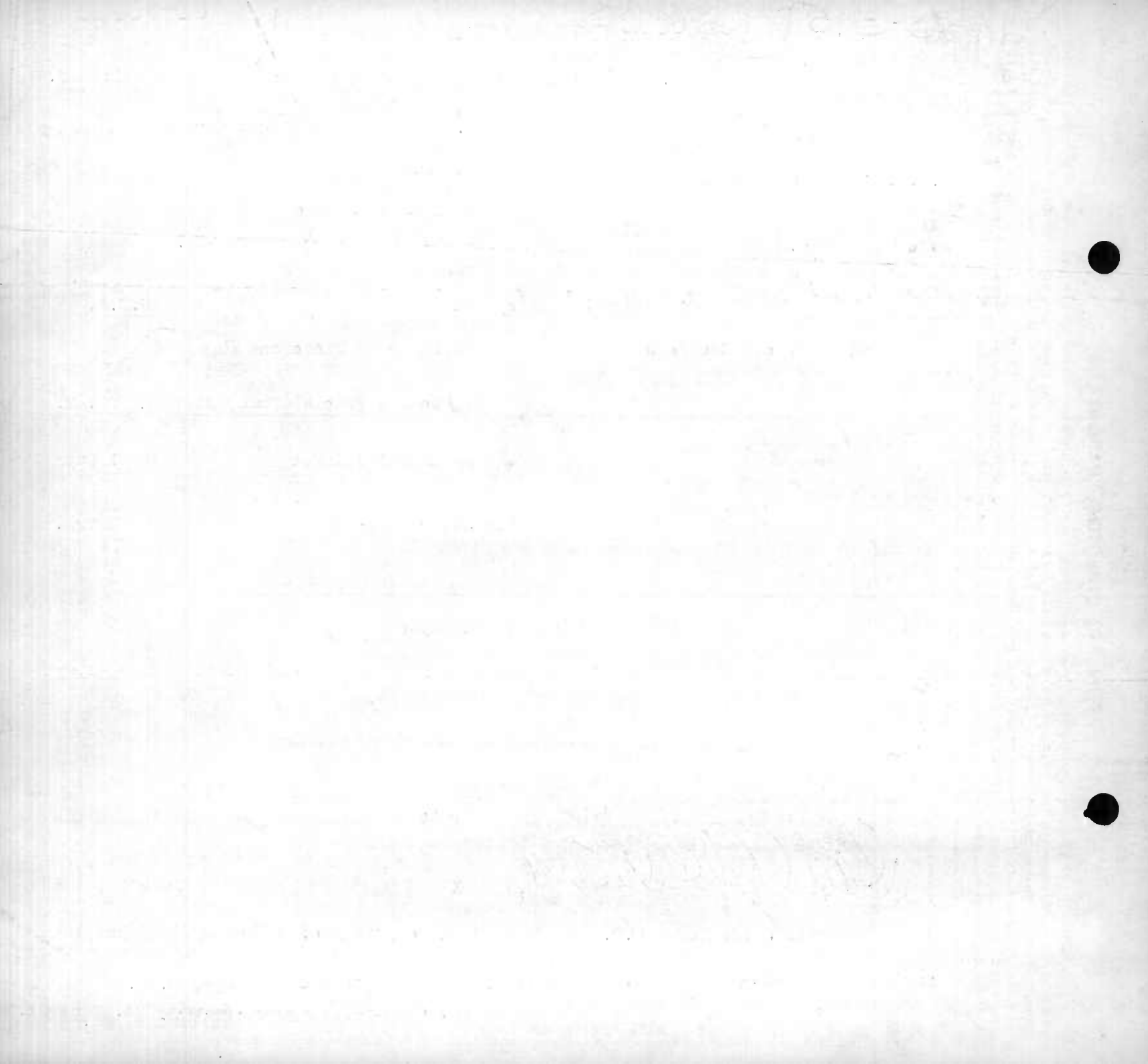
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-622 68-6801				BALTIMORE CITY HEALTH DEPARTMENT		68-6801	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Joseph C. Jerousek				2. DATE AND HOUR OF DEATH June 30, 1968 11 4 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 127 N. Duncan Street				A. STATE Maryland		B. COUNTY	
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 127 N. Duncan Street							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-13	9. AGE (In years lost birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph J. Jerousek				14. MOTHER'S MAIDEN NAME Aloise Winkler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 03 7505		17. INFORMANT Mary M. Jerousek			
				ADDRESS 127 N. Duncan Street			
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ca of lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/24 19 68 to 6/30 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Julius H. Goodman				23B. DATE SIGNED 7/1/68			
23C. PHYSICIAN'S NAME (Type) JULIUS H. GOODMAN MD				23D. ADDRESS 3400 E. BALTIMORE ST			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Julius H. Goodman		25C. FUNERAL DIRECTOR Thy E. Czech		ADDRESS 1211 Chesaco Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

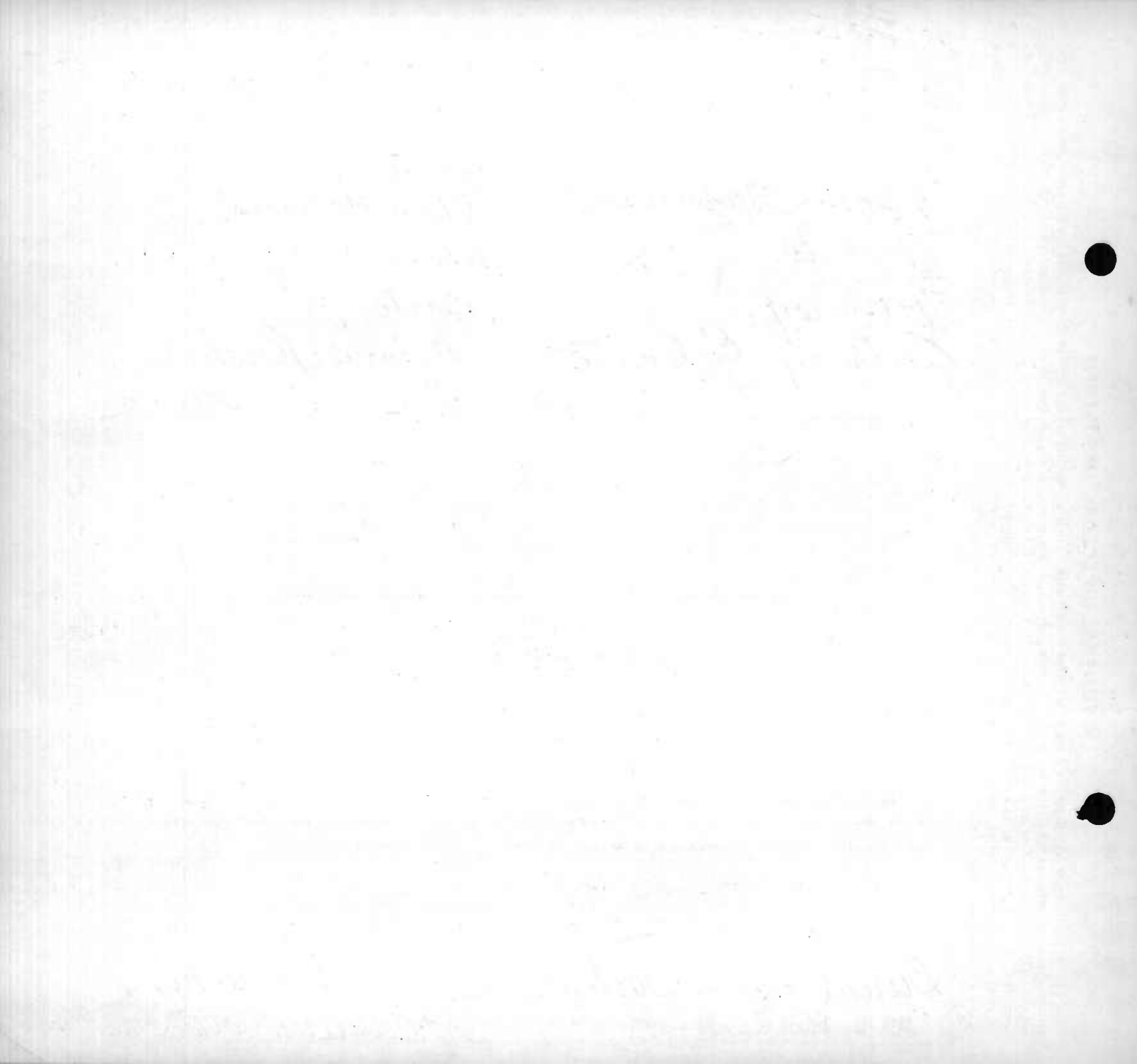
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6802	
5-315 68-6802				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) FRED M. STEFFENS				June 25, 1968 11:56 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) D.O.A. St. Agnes Hospital				A. STATE Md. B. COUNTY Prince George	
				C. CITY OR TOWN Laurel D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 8802 Hunting Lane	
5. SEX Male	6. RACE Cay.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1898	9. AGE (In years last birthday) 70 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			Plumbing-Wholesale	New York	U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Fred Michael Steffens				Johanna Tiedemann	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
?		?	Leo Kearns Funeral Home, Richmond, N. Y.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
I				1 Day	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
Myocardial Infarct					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
Coronary Artery Disease				5 Yrs.	
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Pulmonary Empidysema	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/23 19 68 to 6/25 19 68, that (I) (we) last saw the deceased alive on 6/18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				June 26, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
David Goldenberg, M.D.				9801 Georgia Ave. Silver Spring, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6-29-68		Lutheran Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Middle Village, N. Y.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 2 1968		Wm. Cook-Brooks		St. Paul St. Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-2001		A-235 68-6803		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6803	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Florence Grace (Ross) Austin</i>				2. DATE AND HOUR OF DEATH <i>June 23 12:11 30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>HERMOSA</i>		C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<i>2604 Hermosa</i>				E. STREET AND NUMBER <i>2604 Hermosa</i>		<i>HERMOSA</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 6, -91</i>	9. AGE (In years last birthday) <i>77</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Anthony Esposito</i>				14. MOTHER'S MAIDEN NAME <i>Minnie Ruckel</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-14-8388</i>		17. INFORMANT <i>Sam</i>		ADDRESS <i>Same</i>	
18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Acute Coronary Occlusion</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A). <i>420.1 II</i> <i>Bronchial Asthma</i>						3 years	
19A. DATE OF OPERATION <i>D -</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <i>Nov 11, 1965</i> to <i>June 22, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 22, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>George Sawyer, M.D.</i>				23B. DATE SIGNED <i>6/24/68</i>		23C. PHYSICIAN'S NAME (Type) <i>GEORGE SAWYER M.D.</i>	
23D. ADDRESS <i>4808 HARTFORD RD.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6/26/68</i>		24C. NAME of CEMETERY or CREMATORY <i>Linwood</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>William C. Taylor</i>		ADDRESS <i>606 Taylor Rd</i>	



1

D-400 68-6804 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-6804

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) HARRY DALY

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ June 29, 1968 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital (DOA) Maryland ANNE ARUNDEL

3. DATE PRONOUNCED DEAD Month Day Year Hour
June 29, 1968 10:32 AM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

6. SEX Male 7. RACE White 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒ C. CITY OR TOWN D. INSIDE CITY LIMITS? 32-00
Brooklyn YES ☒ NO ☐

9. DATE OF BIRTH 10. AGE (In years lost birthday) 54 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME JOHN DALY

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MD. SHIP & DRY DOCK 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME ROSE BROWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. SOCIAL SECURITY NO. 18. INFORMANT ADDRESS
Richard Daly 106 Broadway Glen Burnie, Md.

19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(A) IMMEDIATE CAUSE Calcific aortic stenosis
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:
Chronic pulmonary emphysema

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No)
Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Approx.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED June 30, 1968
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 7/2/68 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY 24D. LOCATION (City, town, or county) (State) BALTIMORE BALTIMORE MD.

25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968 25B. NAME OF REGISTRAR Robert E. Feltner 25C. FUNERAL DIRECTOR ADDRESS McColly - Baltimore Md.

WALTER P. HARRIS

Chas. J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> W=123 68-6805 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>68-6805</u>	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>James F. Webster</u>	
2. DATE AND HOUR OF DEATH <u>6/29/68</u> <u>3:35 P</u> M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY _____		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3223 Elmley Avenue</u>		5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2/9/89</u> 9. AGE (In years last birthday) <u>79</u>		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jacob P. Webster</u>		14. MOTHER'S MAIDEN NAME <u>Laura K. Windsor</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-07-7854</u>	
17. INFORMANT <u>Mr. James H. Webster (son)</u>		ADDRESS <u>1243 Neighbors Ave. Baltimore, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Sepsis</u>		CAUSE OF DEATH <u>Sepsis</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Septicemia & gallbladder</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia & gallbladder</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia & gallbladder</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Septicemia & gallbladder</u>	
19. DATE OF OPERATION <u>5/29/68</u>		20. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from _____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Donald J. Ruck</u>	
23B. DATE SIGNED <u>6/29/68</u>		23C. PHYSICIAN'S NAME (Type) _____	
23D. ADDRESS <u>Baltimore, Maryland</u>		24. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	
24B. DATE <u>July 2, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebron Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Hebron, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>	
25B. NAME OF REGISTRAR <u>Donald J. Ruck</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc.-Balto, Md.-14</u>	

Paula Catigati

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~~Paula Catigati~~

V-524

68- 6806

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6806

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT VON CULIN		2. DATE Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6 30 68 11:20a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3 W Barney St. D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1968 11:20a M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/31/19		10. AGE (In years lost birthday) 48	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coffee		14B. KIND OF BUSINESS OR INDUSTRY Taper Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Family - Same		ADDRESS	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-3-68	
24C. NAME OF CEMETERY or CREMATORY Green Hill		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR McCully - 130 E. Fort Ave.		ADDRESS	

MAIL

BY

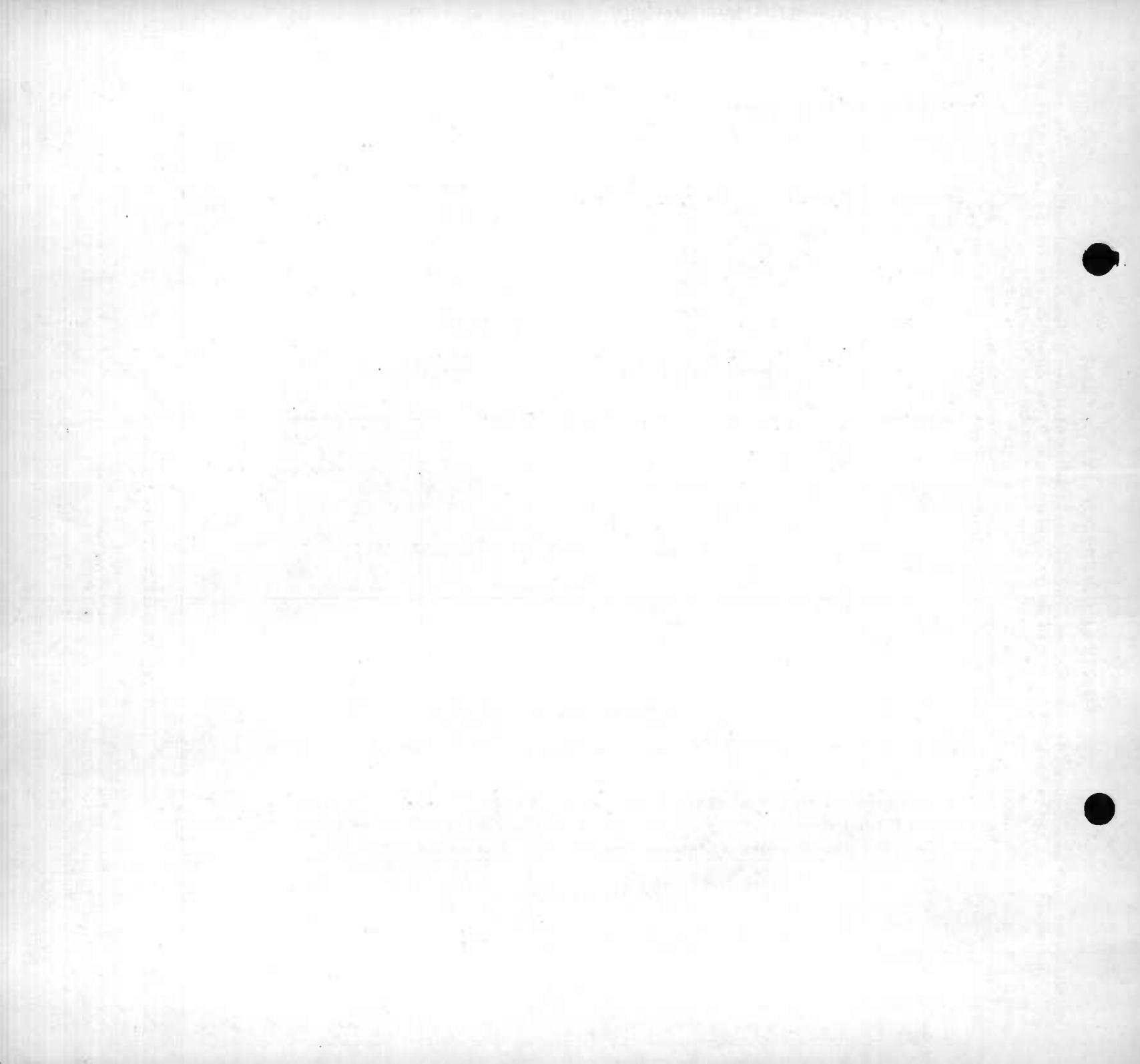
POST

10/1/44

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

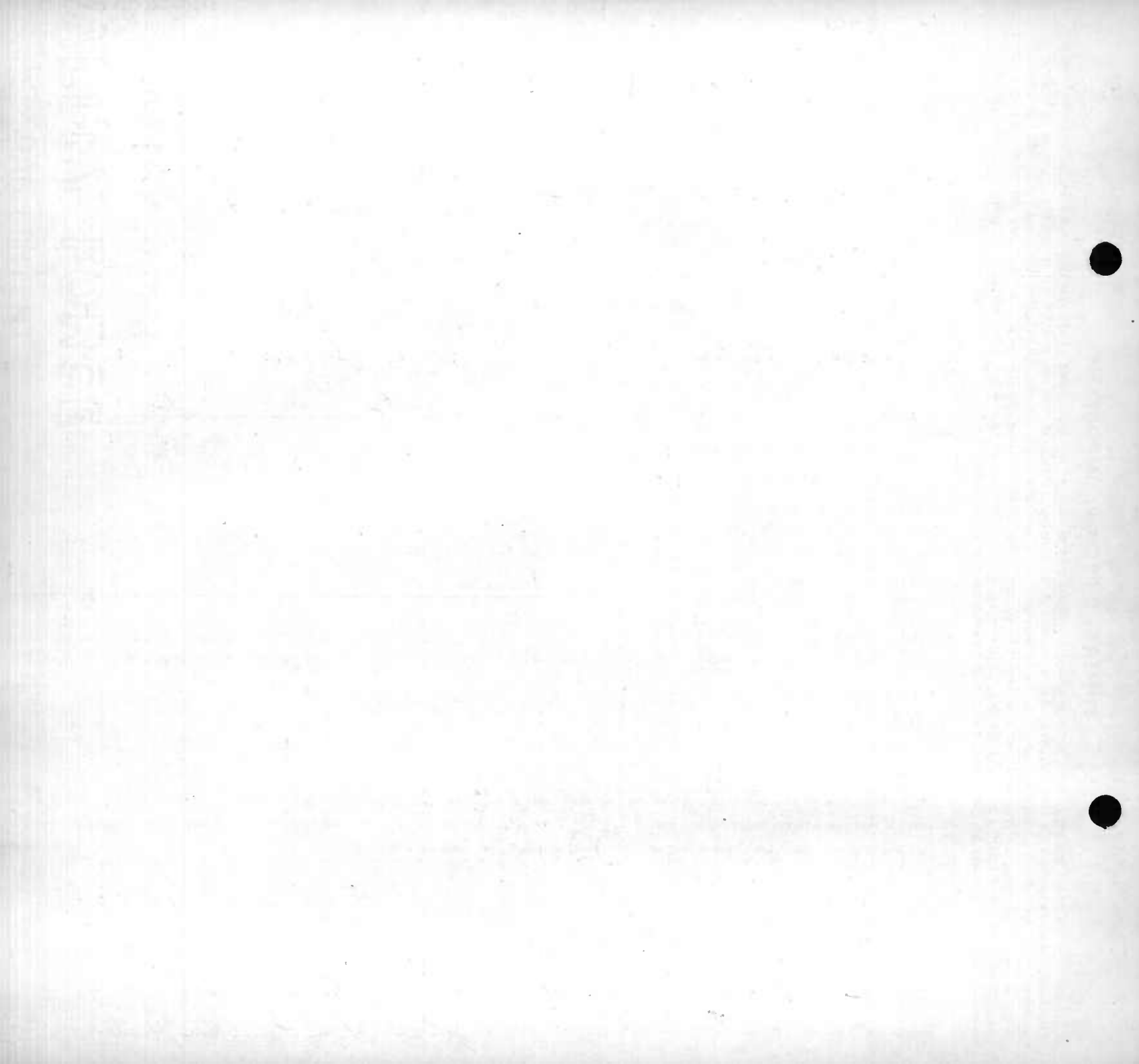
V-400 68- 6807		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6807	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) VAHLE, JOHN		2. DATE AND HOUR OF DEATH 6-30-1968 10:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 367 FRANKLIN SQUARE HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-20-90		9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES VAHLE	
14. MOTHER'S MAIDEN NAME Henrietta Falk		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-28-4336	
17. INFORMANT Chart record		18. 726X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cor Pulmonale		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 434.4 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF: (B) (C)	
22. I certify that (I) (this hospital) attended the deceased from 6-28-1968 to 6-30-1968 , that (I) we last saw the deceased alive on 6-30-1968 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) We (did) did not view the body after death.		23A. SIGNATURE J. Lee M.D.		23B. DATE SIGNED 6-30-68	
23C. PHYSICIAN'S NAME (Type) J. Lee		23D. ADDRESS FRANKLIN SQUARE HOSPITAL		24. LOCATION (City, town, or county) (State) Balt. Md.	
24A. BURIAL, CREMATION, REMOVAL (Specify) B		24B. DATE 7-5-68		24C. NAME OF CEMETERY OR CREMATORY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 130 E. FORT ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

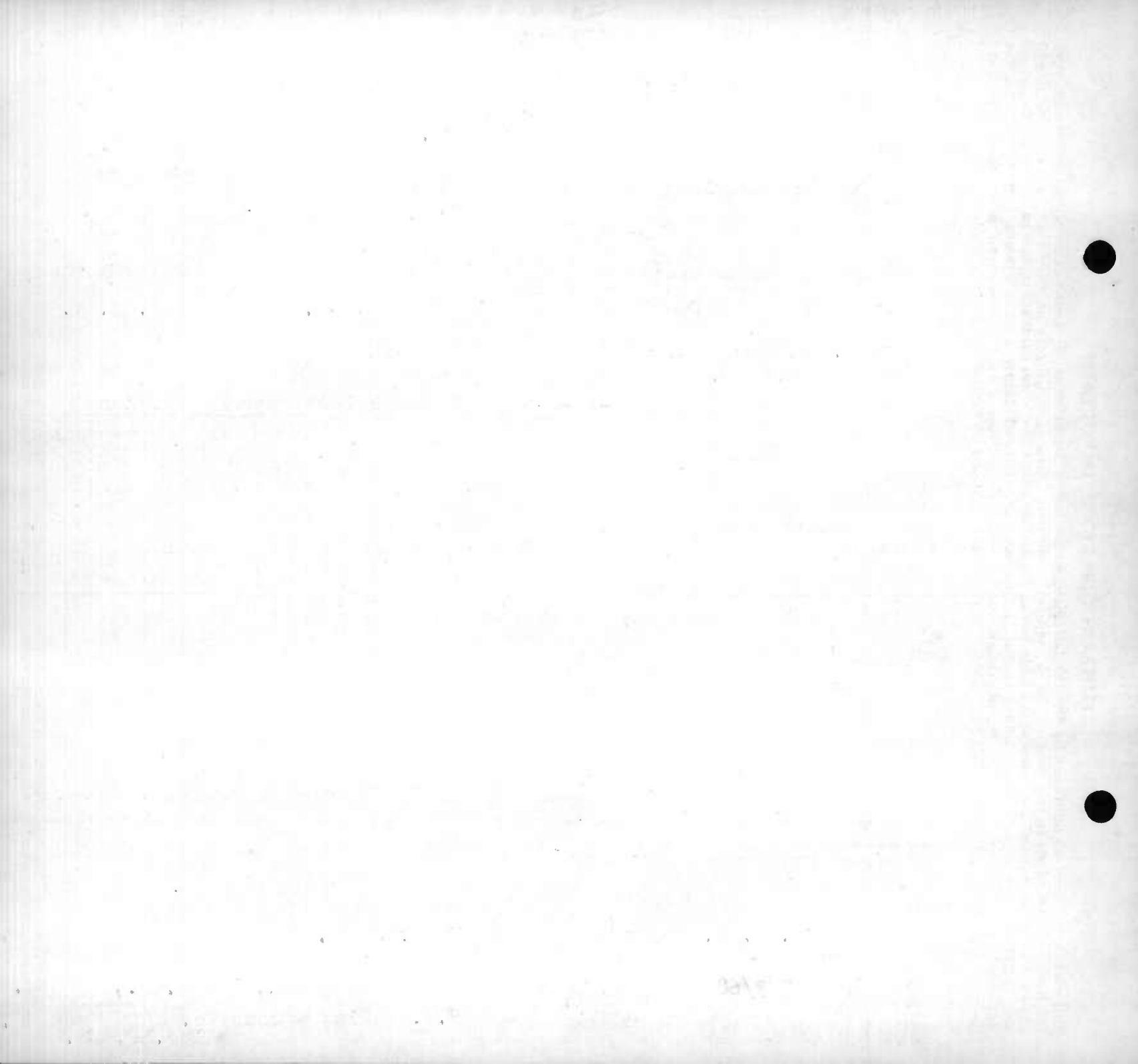
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6808	
1. NAME OF DECEASED (Type or Print) <div style="font-size: 1.5em; font-family: cursive;">Steven Taylor</div>		2. DATE AND HOUR OF DEATH <div style="font-size: 1.2em; font-family: cursive;">12:00 Noon, 6/29/68</div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="font-size: 1.2em; font-family: cursive;">43 South Balto. Gen. Hosp.</div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="font-size: 1.2em; font-family: cursive;">Md. Balto. 823 Herndon Ct.</div>			
5. SEX <div style="font-size: 1.2em; font-family: cursive;">Male</div>		6. RACE <div style="font-size: 1.2em; font-family: cursive;">W</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em; font-family: cursive;">Infant</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em; font-family: cursive;">None</div>		8. DATE OF BIRTH <div style="font-size: 1.2em; font-family: cursive;">July 13, 1967</div>	
13. FATHER'S NAME <div style="font-size: 1.2em; font-family: cursive;">Joseph Taylor</div>		14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em; font-family: cursive;">Alice Lucas</div>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em; font-family: cursive;">No</div>		6. SOCIAL SECURITY NO.		17. INFORMANT <div style="font-size: 1.2em; font-family: cursive;">Family</div>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <div style="font-size: 1.5em; font-family: cursive;">486X I</div>		CAUSE OF DEATH <div style="font-size: 1.2em; font-family: cursive;">Cerebral Edema</div>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em; font-family: cursive;">Bilateral Pneumonia (Extensive)</div>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="font-size: 1.2em; font-family: cursive;">490X II</div>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em; font-family: cursive;">8:30 AM, June 29, 1968</div> to <div style="font-size: 1.2em; font-family: cursive;">12:00 Noon 6/29, 1968</div> that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em; font-family: cursive;">12:00 Noon 6/29, 1968</div> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <div style="font-size: 1.5em; font-family: cursive;">Joy S. Chung</div>				23B. DATE SIGNED <div style="font-size: 1.2em; font-family: cursive;">6/30/68</div>	
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em; font-family: cursive;">Same S. Chung, M.D.</div>				23D. ADDRESS <div style="font-size: 1.2em; font-family: cursive;">S B & H</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em; font-family: cursive;">Burial</div>		24B. DATE <div style="font-size: 1.2em; font-family: cursive;">7-2-68</div>		24C. NAME OF CEMETERY or CREMATORY <div style="font-size: 1.2em; font-family: cursive;">Green Haven Cem</div>	
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em; font-family: cursive;">Green Burnside, Md</div>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
<div style="font-size: 1.2em; font-family: cursive;">John L. Funeral Home, 4200 Pennsylvania Ave</div>		<div style="font-size: 1.2em; font-family: cursive;">John L. Funeral Home, 4200 Pennsylvania Ave</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

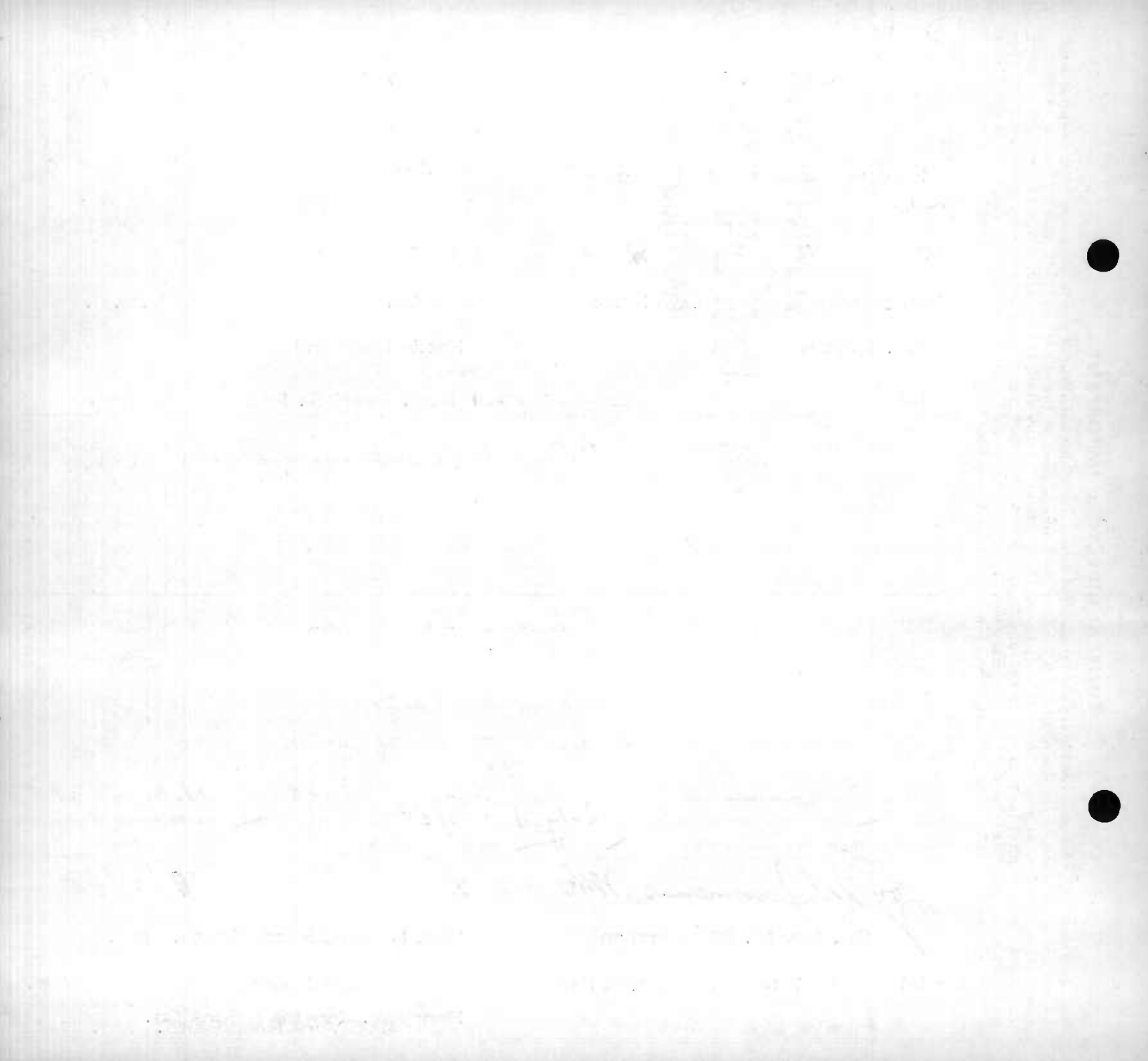
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-452		68- 6809		68- 6809	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Rosella Jane Helmstetter		June 30, 1968		7 ¹⁵ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
60 614 Tunbridge Road		Md. C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		614 Tunbridge Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/20/1918	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John A. Ratigan		Lily Buck			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-12-2469		William Helmstetter (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Metastatic Carcinoma (Primary Breast) Chest, Liver, Spleen, Adrenals (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1968 to June 30 th 1968, that (I) (we) last saw the deceased alive on June 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. W. H. Woody		7-2-68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. W. H. Woody		1403 Park Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/3/68		Woodlawn	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
Woodlawn, Balto. Co., Md.		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1968		R. E. E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6810	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Nettie M. Sparrow		2. DATE AND HOUR OF DEATH 7-1-68 1:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Gardens Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 709 Cedarcroff Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-1886	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME W. Easton		
14. MOTHER'S MAIDEN NAME Hattie Redmond			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-54-7262		17. INFORMANT Mrs. Pearl S. Hood		ADDRESS (Same)	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Cardio-vascular Disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Emphysema					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 68 to July 19 68 that (I) (we) last saw the deceased alive on July 1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Loy M. Zimmerman M.D.				23B. DATE SIGNED 7/2/68	
23C. PHYSICIAN'S NAME (Type) Dr. Loy M. Zimmerman		23D. ADDRESS 3202 Harford Road Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto.; Md. 21212			



Baltimore City Health Department

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6811

BIRTH NO. D-635

1. NAME OF DECEASED (Type or Print) BENJAMIN F. DURDING		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 1, 1968 2:30 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6113 Dunroming Road		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1968 2:30 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Feb. 21, 1898		10. AGE (In years lost birthday) 70	
11. BIRTHPLACE (State or foreign country) Rock Hall, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Sales Mgr. Continental Can Co.		14B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-05-1745	
18. INFORMANT Mrs. Myrtle I. Durdning		ADDRESS (Same)	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pulmonary Emphysema	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/2/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

VS 151-REV. 1/1/68

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6812
C-436		68- 6812		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Alice L. Calder		June 30, 1968 8:21p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Montebello State Hospital			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			907 Belgian Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-28-1897	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		OWN Home		Baltimore, Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Malcolm Herring		Rose Ellis		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-14-6943		Hospital Chapl B.H. Browner 21229 709 Highland Dr.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			Carcinoma of right breast 10 years		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF: with metastases		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Rheumatic heart disease & candidiasis		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 7 1968 to June 30 1968, that (I) (we) last saw the deceased alive on June 30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Cesar J. Pellerano				6-30-68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Cesar J. Pellerano				Montebello Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/3/68		Greenmount	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 2 1968		Robert E. Taylor		H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.	

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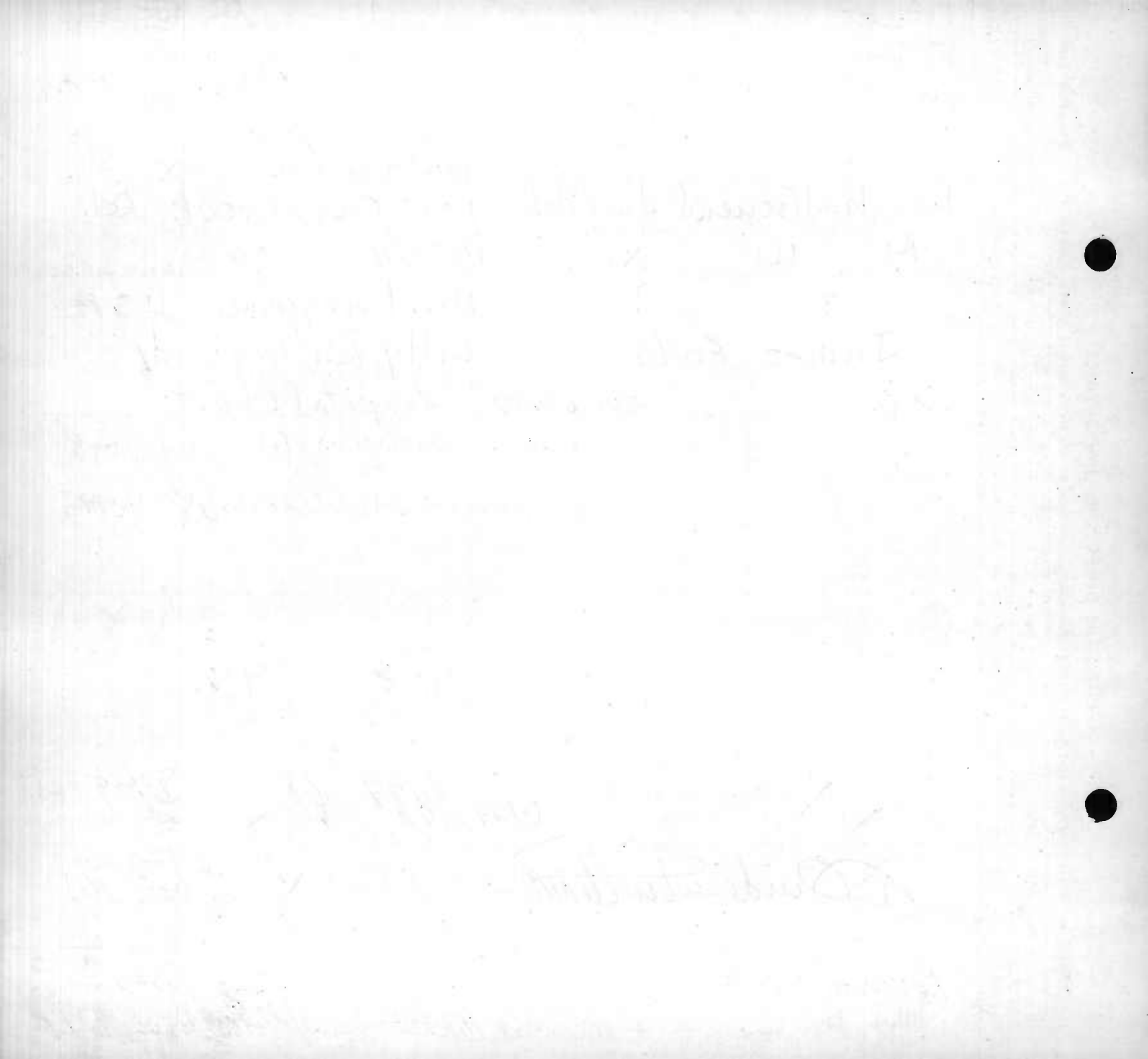
(10)

LEADERS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6813	
E-320 68- 6813				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Howard Eads</u>		2. DATE AND HOUR OF DEATH <u>6/29/68</u> <u>11 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>21212 Balt Co.</u> 53-00		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1010 Overbrook Rd.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/27/11</u>	9. AGE (In years lost birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Eads</u>		14. MOTHER'S MAIDEN NAME <u>Lilly Rutherford</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>234 10 8644</u>		17. INFORMANT <u>Hospital Chart</u> ADDRESS	
18. <u>403X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>UREMIC PNEUMONITIS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIO SCLEROSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A) <u>446X</u> II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29 6/27 1968</u> to <u>6/29 1968</u> , that (I) (we) last saw the deceased alive on <u>6/29 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>6/29/68</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>6/30/68</u>		24C. NAME OF CEMETERY or CREMATORY <u>Beckley, W. Va</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1968</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home 6500 York Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

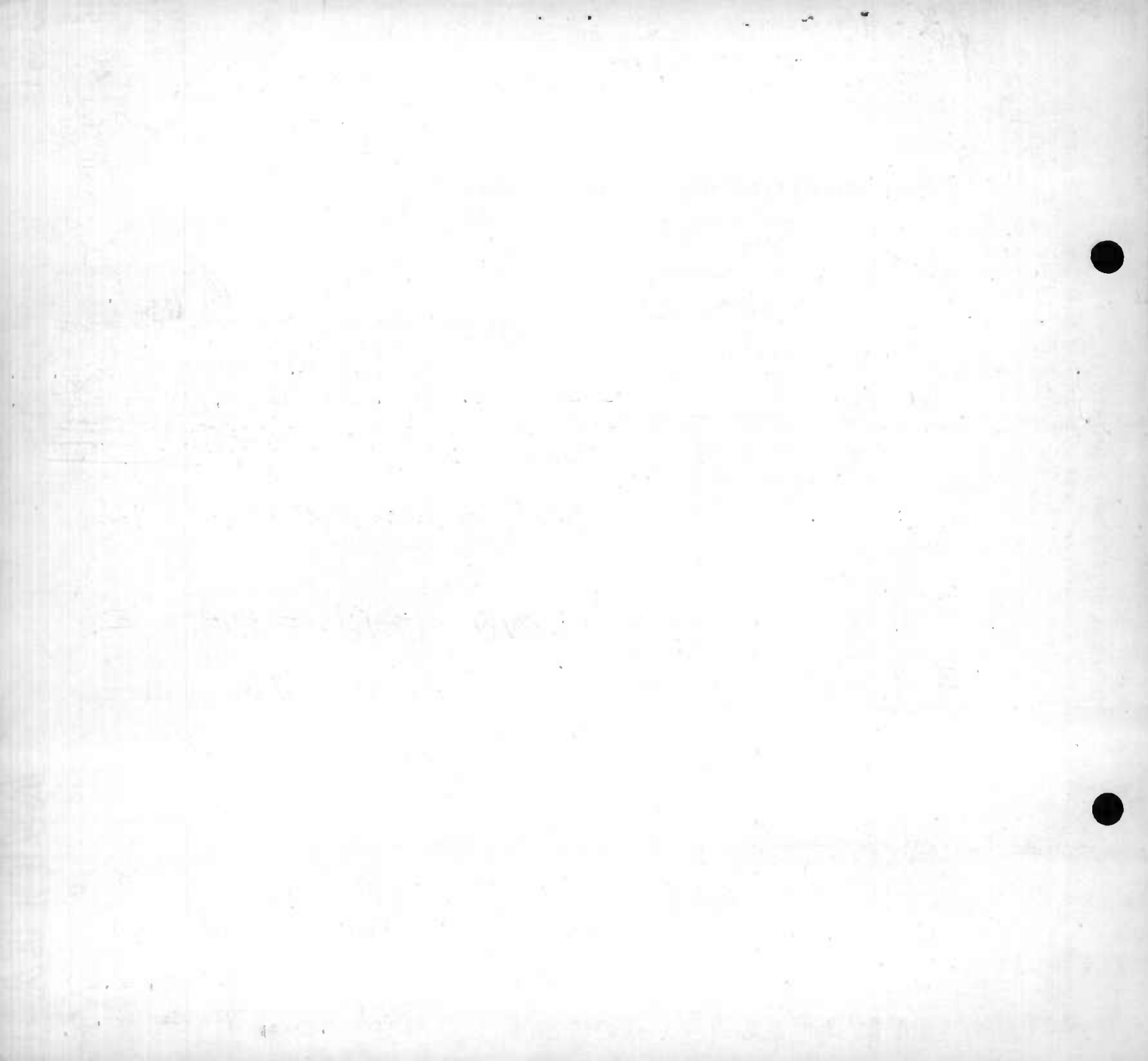
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6814	
P-460 68- 6814		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) POLLER, Lavinia M.		6-27-68 12 ⁵⁰ /A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital 43		A. STATE MD B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		E. STREET AND NUMBER 413 E. Lorraine Ave.	
6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-21-90		9. AGE (In years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) D.C.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK HARPER.		14. MOTHER'S MAIDEN NAME CATHERINE FINLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-10-9949	
17. INFORMANT Miss Katharine M. Bare		ADDRESS 413 Lorraine Ave. 18	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ostehenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD CONGESTIVE HEART FAILURE DIABETES MELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-26 1968 to 6-27 1968 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Larry J. Warner M.D.		23B. DATE SIGNED 6/27/68	
23C. PHYSICIAN'S NAME (Type) LARRY J. WARNER M.D.		23D. ADDRESS S.B.G.H. 1213 Light St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/68	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park		24D. LOCATION (City, town, or county) (State) Howard Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd-12	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-6815	
1. NAME OF DECEASED <i>Bessie Klingelhofer</i> (Type or Print)				2. DATE AND HOUR OF DEATH <i>6/28/68 12:15 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Maryland General Hosp</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore Co</i> C. CITY OR TOWN <i>Edgemere</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>Box 64 Rte 10</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-05-83</i>		9. AGE (In years, lost birthday) <i>84</i>	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia "Europe" (Czech)</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>James Zika</i>				14. MOTHER'S MAIDEN NAME <i>Barbara Furst</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-01-6641</i>		17. INFORMANT (Husband) <i>Rt. 10 Box 64 Balto, MD. 21219</i> <i>Mr. Karl A. Klingelhofer, Millers Island Rd.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Rupture of Aortic Aneurysm</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>AS CVD ; HYPERT. (H) H</i>				IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>AS CVD ; HYPERT. (H) H</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) <i>45-IX II</i>							
19A. DATE OF OPERATION <i>6/26/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fracture hip</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? <i>Rt 64 Rte 10</i>			
21D. TIME OF INJURY (APPROX.) <i>6/28/68 AM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Accidental</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>6/22/68</i> 19 <i>68</i> to <i>6/28</i> 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>6/28</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Nicholas C. Bosch MD</i>				23B. DATE SIGNED <i>6/28/68</i>		23C. PHYSICIAN'S NAME (Type) <i>Nicholas C. Bosch MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fajana</i>		25C. FUNERAL DIRECTOR <i>Duda John J. Duda,</i>		25D. ADDRESS <i>7922 Wise Ave. Dundalk Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

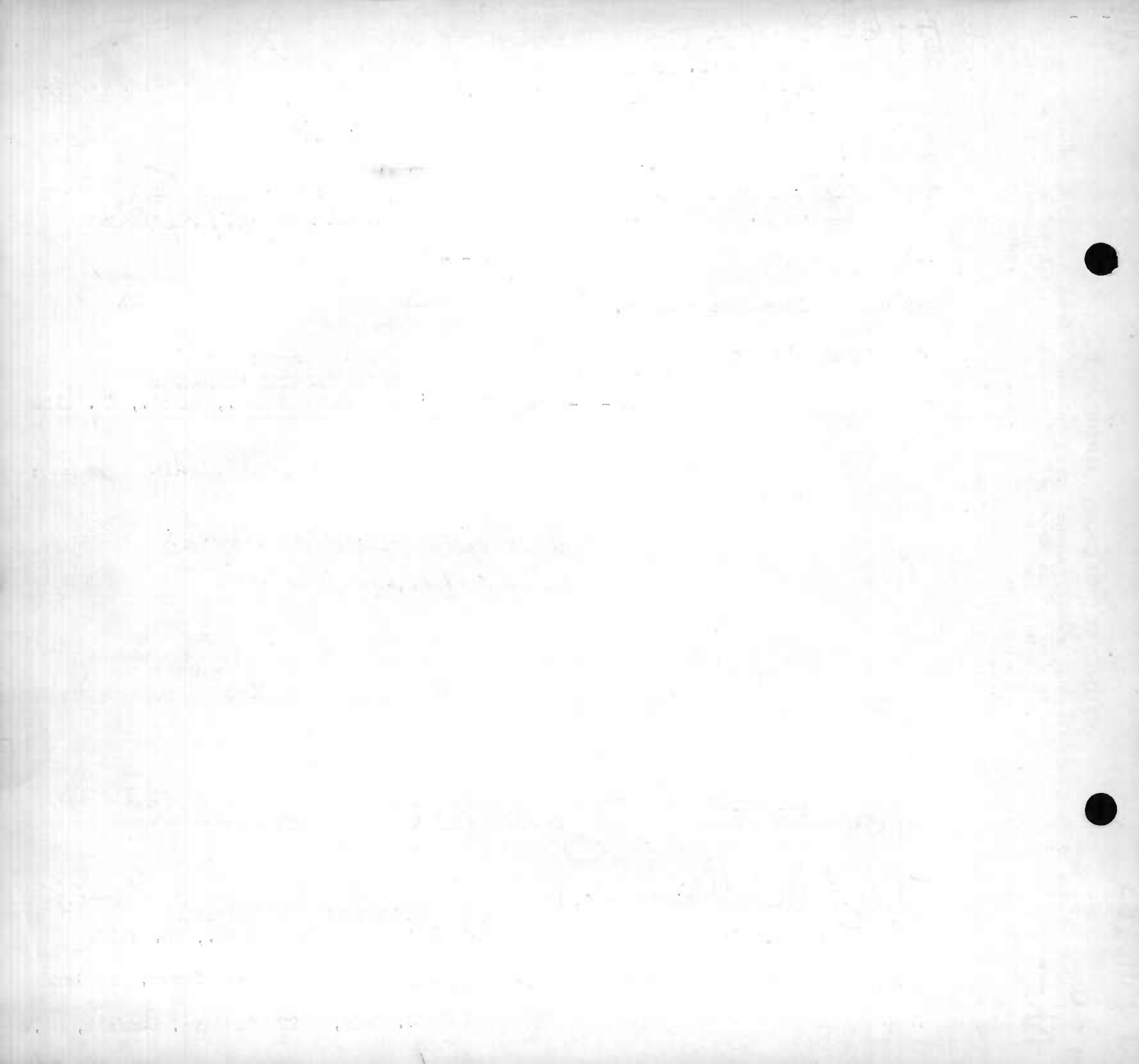
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

37-66-83 11		A-130		68-6816		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6816	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JULIA ABBOTT				2. DATE AND HOUR OF DEATH 6/28/68 2:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224						C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7849 BONIFACE LANE 21222									
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-09		9. AGE (In years last birthday) 58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UPTON BRUMMEL						14. MOTHER'S MAIDEN NAME NETTIE AGNEW			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-09-4296		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS 4940 EASTERN AVENUE #21224			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2509 Septis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. diabetes mellitus						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: one day (B) DUE TO, OR AS A CONSEQUENCE OF: 20 years (C) _____			
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 260X									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/30 19 68 to 6/28 19 68 , that (I) (we) last saw the deceased alive on 6/28 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Niel Brands M.D.						23B. DATE SIGNED 6/28/68			
23C. PHYSICIAN'S NAME (Type) Dr. BRANDS M.D.						23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6817	
A-653 68- 6817 CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Anthony C. Arend Anthony C. Arend			2. DATE AND HOUR OF DEATH 6/30/68 4:46 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Balto		
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue BALTIMORE, MARYLAND 21224			C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE			6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter Chesapeake Shoe Co.			8. DATE OF BIRTH 6-5-94		9. AGE (In years lost birthday) 74
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOHN Cicotta			14. MOTHER'S MAIDEN NAME ANGELA Greado		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-0-2585 A		17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVE., BALTO., MD. 21224
18. 453 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolus 10 min (B) Multiple Pulmonary emboli 20 days (C) Venous thrombosis 20 days		
18. 466 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/30/68 19 to 6/30/68 1928, that (1) (we) lost saw the deceased alive on 6/30/68 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Neil R. Williamson MD				23B. DATE SIGNED 6/30/68	
23C. PHYSICIAN'S NAME (Type) NEIL R. WILLIAMSON MD				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 2 1968			
25A. NAME OF REGISTRAR Robert E. Salisbury		25B. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25C. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-500 68- 6818				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6818	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) KATHERINE Cecilia OWEN				2. DATE AND HOUR OF DEATH 10:15 AM 6/29/68 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 MGH. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4656 Park Heights Ave 21215			
5. SEX F	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/23/94	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days 0 0		If Under 24 Hrs. Min. 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) M.D.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Fisher William Patrick Fisher				14. MOTHER'S MAIDEN NAME KATHERINE Catherine Prestley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-0053D		17. INFORMANT ADDRESS Thomas J. Owen, Jr. 2231 Ellen Ave. 21234			
18. CAUSE OF DEATH							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mi	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCT 5 da		(C) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE FAILURE 5 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not-White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/29 6:06 to 6/29 19 , that (I) (we) last saw the deceased alive on 6/29 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6/29/68			
23C. PHYSICIAN'S NAME (Type) ARK R WILKE		23D. ADDRESS MGH					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 2 Jul. '68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 4611 Park Hghts Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6819
<div style="display: flex; justify-content: space-between;"> H-252 68- 6819 CERTIFICATE OF DEATH </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Mildred Huggins</u>			2. DATE AND HOUR OF DEATH <u>6/30/68</u> <u>830 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Worcester</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>			C. CITY OR TOWN <u>Snow Hill</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER <u>Rt#2</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/26</u>	9. AGE (In years last birthday) <u>41</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Produce Co. Office</u>	11. BIRTHPLACE (State or foreign country) <u>J.Y. New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Oscar Berilla</u>			14. MOTHER'S MAIDEN NAME <u>Vera - Pastorek</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>44-11-1111</u>	17. INFORMANT <u>Hospital Chart</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>430.9 I</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>subarachnoid hemorrhage</u>		
			(B) <u>Aneurysm ant. communicating</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>330X II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/22/68</u> 19 to <u>6/30/68</u> 19, that (I) (we) lost saw the deceased alive on <u>6/30/68</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ivan L. Butler M.D.</u>			23B. DATE SIGNED <u>6/30/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>IVAN L. BUTLER M.D.</u>			23D. ADDRESS <u>UNIVERSITY HOSPITAL, BALTO. MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>7/3/68</u>	24C. NAME OF CEMETERY <u>Whateast Methodist</u>	24D. LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 3 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>James F. Williams, Snow Hill, Md.</u>		

M-610
B-600

A-325 68-6820 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6820

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MYRTLE VIRGINIA ATKINS (MURPHY-BARROW)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 18 68 11:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 18 1968 11:00 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 2-26-14		10. AGE (In years last birthday) 54		E. STREET AND NUMBER 867 Park Ave.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward W. Simpson	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME MARY A. WHITE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. Unknown		18. INFORMANT ADDRESS Doris Vestal 9446 Crest Dr. Calver Springs Md.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E890X Smoke and Fume Inhalation due to (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Conflagration (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11-02			
20A. DATE OF OPERATION E916.0 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 867 Park Avenue 11-02	
22D. TIME OF INJURY (APPROX.) June 18, 1968 10:10 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Careless smoking	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED June 19, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 7-1-68		24C. NAME OF CEMETERY or CREMATORY GREEN MOUNT CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS P.F. CUNCH 1211 CHESACO AVE	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-63 68-11570 68-6821		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6821	
Janet L. Carter		CERTIFICATE OF DEATH			
BIRTH NO. Mother's Case # 51-58-14		2. DATE AND HOUR OF DEATH 6/26/68 8:25 P.M.			
1. NAME OF DECEASED (Type or Print) CARTER, BABY GIRL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Ave. Baltimore, Md. BALTIMORE CITY HOSPITALS. 31 PREM. NURSERY. #21224		E. STREET AND NUMBER 6 Armor Court		# 21220	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/68	9. AGE (In years last birthday) 20	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10B. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARL B. Carter		14. MOTHER'S MAIDEN NAME Janet Brandy Bandy		ADDRESS # 21224	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		ADDRESS # 21224	
18. 510X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hours	
This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Asphyxia -			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypoxia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Bronchopulmonary Fistula			
518X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/25/19 68 to June 26, 19 68, that (I) (we) last saw the deceased alive on 6/26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. Mayman M.D.		23B. DATE SIGNED 6/26/68			
23C. PHYSICIAN'S NAME (Type) D. MAYMAN M.D.		23D. ADDRESS 4940 Eastern Ave. Baltimore, Maryland #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE June 20/1968	24C. NAME OF CEMETERY or CREMATORY Sharon Methodist Cemetery	24D. LOCATION Rocks	Harford Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968	25B. NAME OF REGISTRAR Robert E. Jackson M.D.	25C. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6822	
C-655 68-6822		CERTIFICATE OF DEATH			
BIRTH NO. 68-11923		1. NAME OF DECEASED (Type or Print) CRIMMINS BABY BOY			
2. DATE AND HOUR OF DEATH		6-28-68 5:10 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
35 CHURCH HOME AND HOSPITAL, BALTIMORE MD.		Md. NEW BORN			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MALE		WHITE		June 28, 1968	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE		NONE		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
THOMAS W. CRIMMINS		Herlinda Goodyear		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		NONE		Mr. Thomas W. Crimmins 2302 Hanson Rd. Edgewood, Md.	
18. 769.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Subarachnoid hemorrhage			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Precipitate Labor.			
19. 760.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6-28-1968 to 6-28-1968, that (I) (we) last saw the deceased alive on 6-28-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
ROBERTA KRAMER		6/28/68			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ROBERTA KRAMER MD		222 W. Cold Spring Lane, BALTIMORE 440			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		July 1, 1968		St. Francis de Sales	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1968		Robert E. Johnson		Howard K. McComas & Son	
				Abingdon, Md.	

CRIMINAL RECORD

1924

CRIMINAL RECORD AND HOSPITAL, BOSTON, MASS.

MALE WHITE

U.S.A.

MASSACHUSETTS

THOMAS W. CRIMINAL

Respiratory failure
Subarachnoid hemorrhage
Post-partum labor

Yes

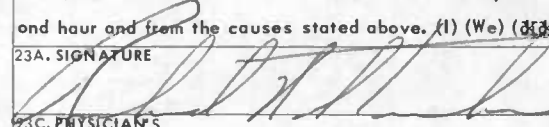
1924

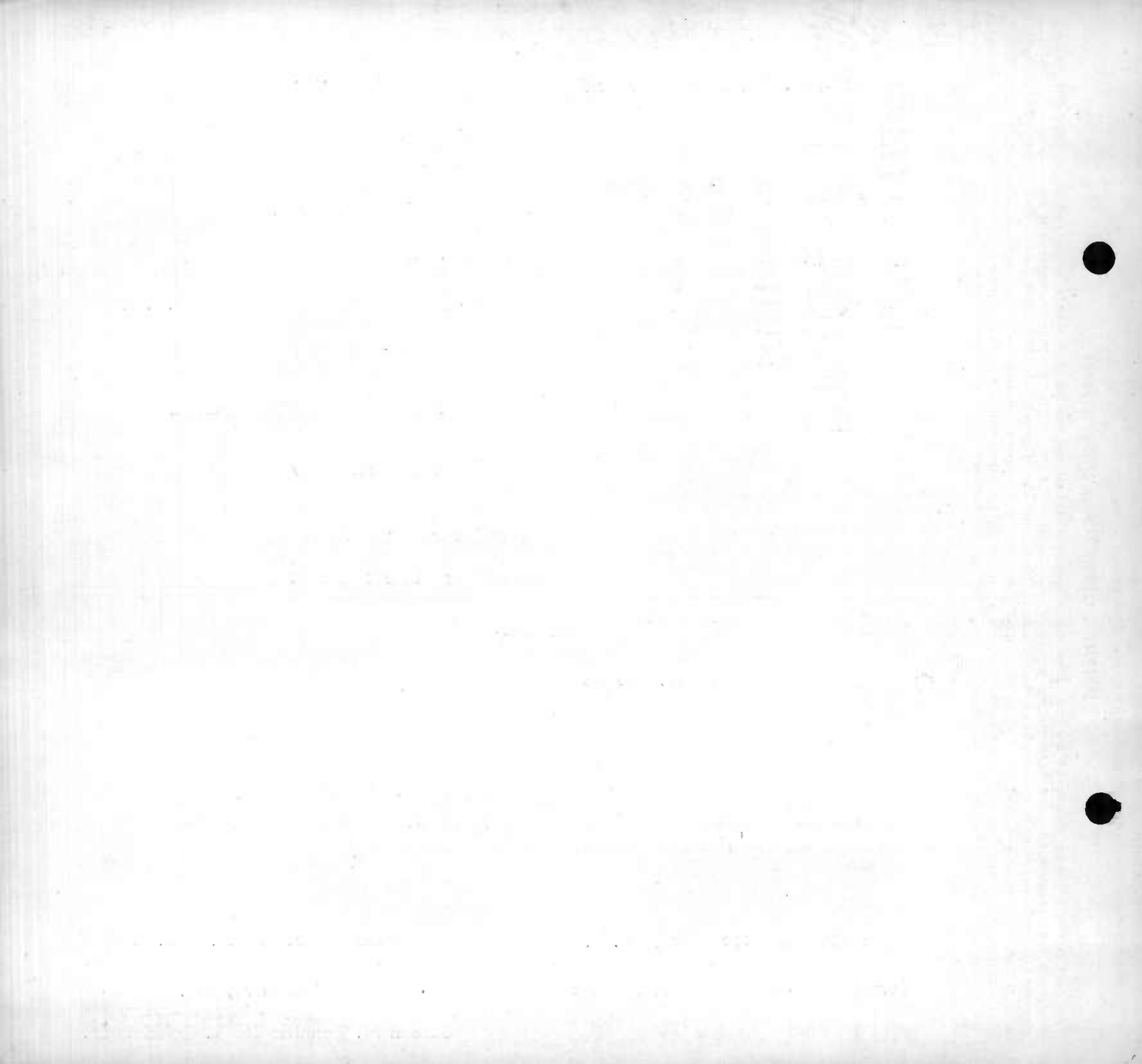
CRIMINAL RECORD

CRIMINAL RECORD

FUNERAL DIRECTOR: IMPORTANT

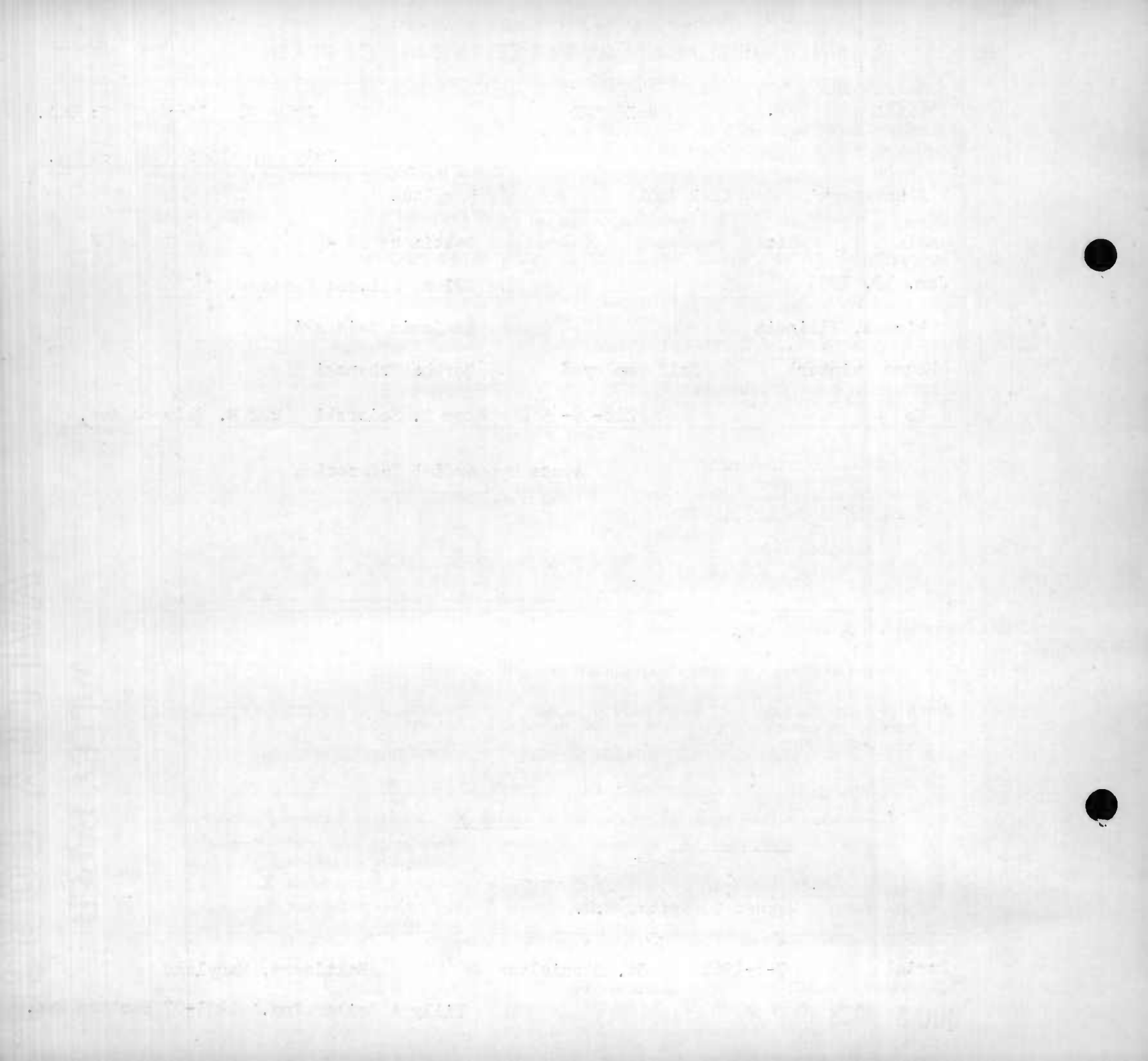
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6823	
T-620		68-6823		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Tillie M. Zeladowski-Turowski		2. DATE AND HOUR OF DEATH 1:45 A.M. June 30, 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3732 Gough Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3732 Gough Street			
5. SEX Fem.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1884		9. AGE (In years lost birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME —			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-34-2741		17. INFORMANT M. Berkey ADDRESS 3732 Gough St.	
18. 174 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pleural effusion DUE TO, OR AS A CONSEQUENCE OF: (B) Pleural carcinomatosis DUE TO, OR AS A CONSEQUENCE OF: (C) carcinoma of left breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170 X II Senility					
19A. DATE OF OPERATION 1961		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca left breast		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/3/67 19 to 5/13 19 68 , that (I) (we) last saw the deceased alive on 5/13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED July 2 '68		23C. PHYSICIAN'S NAME (Type) Richard W. Steenburg, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Holy Rosary	
24D. LOCATION Baltimore, Md.		24E. ADDRESS 4940 Eastern Ave. Balto. Md. 21224			
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Joseph N. Zanni ADDRESS 263 S. Conkl ng St.	



1
S-620 68-6824 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-6824

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) FRANK W. SAIERSKI		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> July 2, 1968 9:30 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1968 9:30 A.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 10, 1903		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 65		E. STREET AND NUMBER 202 N. Ellwood Avenue	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? Benjamin Saierski	
13. FATHER'S NAME Benjamin Saierski		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Painter	
15. MOTHER'S MAIDEN NAME Bertha Urbanski		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-09-8564		18. INFORMANT Rose M. Saierski	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 410.91 420.1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7-6-1968		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/2/68			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1968	
24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	



MS22

68- 6825

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6825

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY A. MANCHESTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> July 1, 1968 Hour noon M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1202 N. Charles Street (DOA)		3. DATE PRONOUNCED DEAD Month Day Year July 1, 1968 Hour 1:56 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-02	
6. SEX male	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/3/1907		10. AGE (In years lost birthday) 61		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Cambridge Vt.		12. CITIZEN OF U.S.A.		E. STREET AND NUMBER 1202 N. Charles Street	
13. FATHER'S NAME Edwin Manchester		14. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Merchant Mar.		15. MOTHER'S MAIDEN NAME Edith Fortin	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 003/013898		18. INFORMANT Cuthur Manchester, Vermont	
19. 492X1		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Pulmonary Emphysema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/2/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68		24C. NAME OF CEMETERY or CREMATORY Jeffersonville	
24D. LOCATION (City, town, or county) (State) Cambridge, Vermont		25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Albert Nick & T. Fisher (LFD)					

B-400
6/26/68
WHS

Approved & released by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6826		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 68- 6826	
1. NAME OF DECEASED (Type or Print) Harvey Lee LEE BAILEY				2. DATE AND HOUR OF DEATH 6/26/68 6:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-15-1905	
9. AGE (In years last birthday) 63		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? Unknown		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Annie Robinson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Geraldine Huff		ADDRESS 2306 Hunter St		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. 5-71-81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Latent, severe leucodystrophy				CAUSE OF DEATH Latent, severe leucodystrophy			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 381.0 II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fatty liver.			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). XS							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/25 1968 to 6/26 1968 , that (I) (we) last saw the deceased alive on 6/26 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. H. Oehlert MD				23B. DATE SIGNED 6/26/68		23C. PHYSICIAN'S NAME (Type) WILLIAM H. OEHLERT MD.	
23D. ADDRESS THE UNION MEMORIAL HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-68		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Sanders		25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E. Preston St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 68-6827

BIRTH NO. 68-6827		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) JAMES R. BANTON Bantom		2. DATE AND HOUR OF DEATH 6/26/68 2:16 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 14-02	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital 38		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1519 ARGYLE AVE. 21217	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed/disabled		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Annie NEAL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 433.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Cardio/respiratory arrest Cardiac arrest A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: B) DUE TO, OR AS A CONSEQUENCE OF: Bovine aspiration during bovine swallow gastric stress ulcers & necrosis with hemorrhage APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 24 19 68 to June 26 19 68, that (I) (we) last saw the deceased alive on June 26 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael B. Troner M.D.		23B. DATE SIGNED 6/26/68	
23C. PHYSICIAN'S NAME (Type) MICHAEL B. TRONER M.D.		23D. ADDRESS University Hosp Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-68	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem Balto.		24D. LOCATION (City, town, or county) Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Talbott	
25C. FUNERAL DIRECTOR Raymond Sanders		25D. ADDRESS 2176 Preston St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6828
1. NAME OF DECEASED (Type or Print) Robert Campbell		2. DATE AND HOUR OF DEATH 27 June '68 4:15 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS ADDRESS OR LOCATION 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-07		
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10B. KIND OF BUSINESS OR INDUSTRY Packing Co.		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME Robert Campbell		14. MOTHER'S MAIDEN NAME Martha Toles		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 251-10-7930-A		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS 4940 EASTERN AVENUE #21224
18. 4309 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 331X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ① Bilateral C.V.A.s. (1 yr) ② Benign prostatic hypertrophy.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: chronic urinary sepsis - tract infection (B) quadriplegia - spinal cord DUE TO, OR AS A CONSEQUENCE OF: (C) congenitally narrow cervical canal.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. 6 mos.
19A. DATE OF OPERATION ? at J.H.H.		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Urinary retention		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (he) (this hospital) attended the deceased from 13 March 1968 to 27 June 1968 , that (I) (we) lost saw the deceased alive on 27 June 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Wanda Lerner M.B.B.S.		23B. DATE SIGNED 27 June 1968		23C. PHYSICIAN'S NAME (Type) V.A. Lennon
23D. ADDRESS 4940 EASTERN AVENUE #21224		23E. NAME OF REGISTERAR CL - BALTIMORE CITY HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-68		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
24D. LOCATION (City, town, or county) Anne Arundel Co. Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 3 1968		
24F. NAME OF REGISTRAR Robert E. Taylor		24G. FUNERAL DIRECTOR Randolph Collick		
24H. ADDRESS 2431 E. Oliver St.				

1084

Western Tele
Larkin Co

Western Tele
Larkin Co

FUNERAL DIRECTOR: IMPORTANT

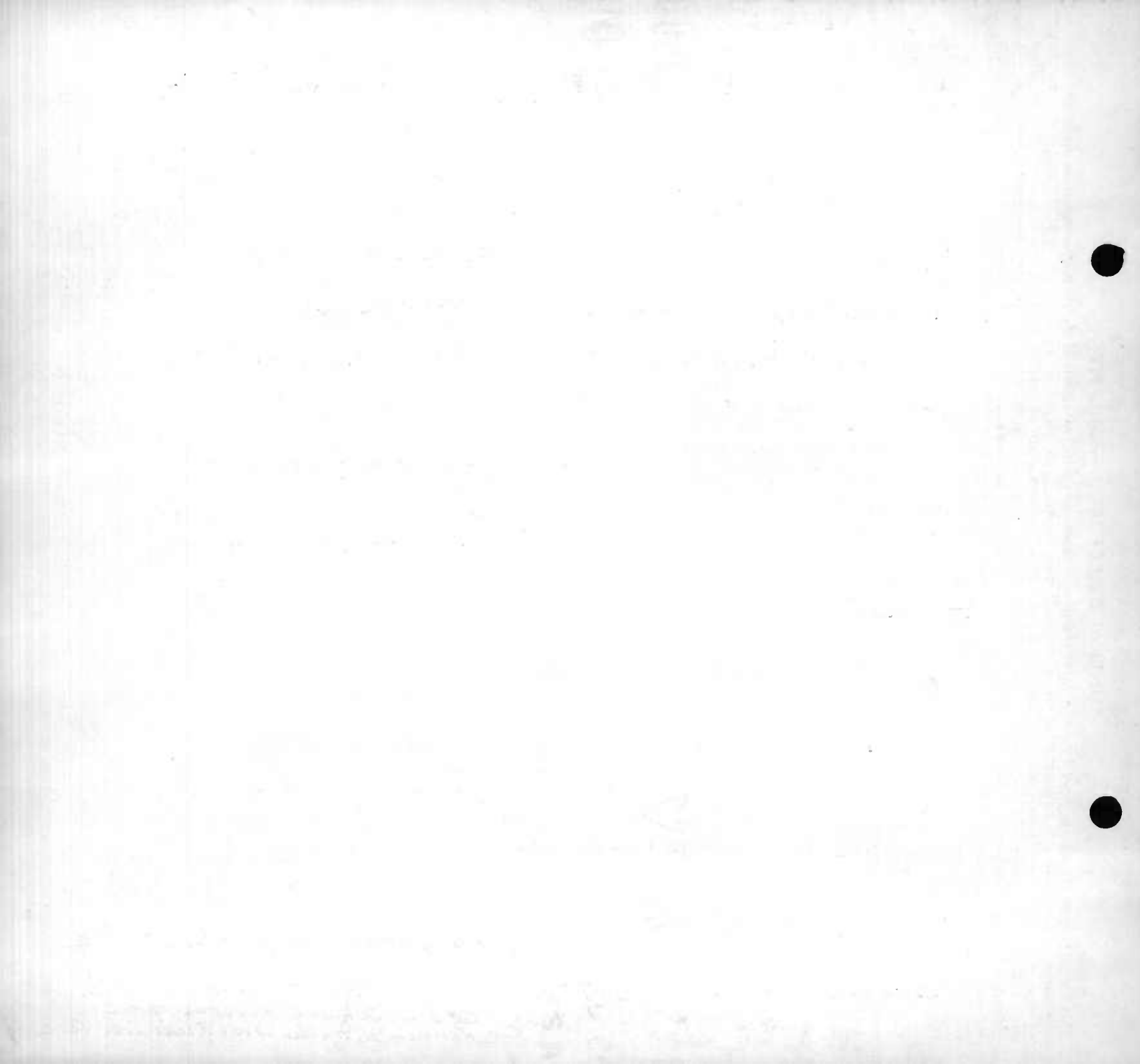
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6829	
BIRTH NO. 68-6829				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mrs. Katri KNUUTILA			2. DATE AND HOUR OF DEATH 7-2-68 10³⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL 34			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 901 Fordwood Circle		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-95		9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) Finland	
13. FATHER'S NAME Karl Wahlroos			14. MOTHER'S MAIDEN NAME ELEONORA HELLEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 091-22-0876		17. INFORMANT CHARLES KAPPEL	
				ADDRESS 901 Fordwood Circle	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 193X4 1250.9 (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 194X II			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cachexia (B) DUE TO, OR AS A CONSEQUENCE OF: Thyroid Cancer (C) Atherosclerosis & Diabetic Mellitus		
19A. DATE OF OPERATION 194X			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-7 1968 to 7-2 1968 , that (I) (we) last saw the deceased alive on 7-2 1968 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>			23B. DATE SIGNED 7-2-68		23C. PHYSICIAN'S NAME (Type) Benito Martinez
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 7-6-68		24C. NAME OF CEMETERY or CREMATORY Wood Lawn
24D. LOCATION (City, town, or county) (State) NEW YORK NEW YORK			25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		
25B. NAME OF REGISTRAR Robert E. Faldut			25C. FUNERAL DIRECTOR Geo. L. Schwartz Francis H. Miller		
25D. HOME ADDRESS 2101 Frederick Ave.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6830	
68-6830				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIAN KIEFER		2. DATE AND HOUR OF DEATH 7/2/68, 1:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2804		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital of Maryland		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY Tailoring		8. DATE OF BIRTH 9-11-89	
13. FATHER'S NAME FRANK Hildebrandt		14. MOTHER'S MAIDEN NAME FREDRICKA KAUFMANN		9. AGE (In years last birthday) 78	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT From chart		ADDRESS From chart		12. CITIZEN OF WHAT COUNTRY? U.S.A	
18. 402X I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
493X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1/68 to 7/2/68 , that (I) (we) last saw the deceased alive on 1:30 PM, 7/2/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. S. Ming		23B. DATE SIGNED 7/2/68		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Dr. Charles Cann		23D. ADDRESS LUTHERAN HOSPITAL of Md.		DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-68		24C. NAME of CEMETERY or CREMATORY WESTERN	
24D. LOCATION BALTIMORE, Md.		24E. NAME of CEMETERY or CREMATORY BALTIMORE, Md.		24F. LOCATION BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Geo. L. Schwab 2101 Frederick Ave	



1

D-540 68- 6831 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6831

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET DONNELLY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 1 68 9:45 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1701 Hollins St.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1968 9:45 a. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11/21/1901		10. AGE (In years lost birthday) 36 67	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. none	
15. MOTHER'S MAIDEN NAME Mary McLaughlin		18. INFORMANT Wm. Black, 2726 Norland Rd. Baltimore, Md.	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Edward F. Wilson EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION BURIAL		24B. DATE 7-3-68	
24C. NAME OF CEMETERY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.	
25C. FUNERAL DIRECTOR Wm. J. Fischer		ADDRESS 2550 Baltimore	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6832	
1. NAME OF DECEASED (Type or Print) Louise Gross				2. DATE AND HOUR OF DEATH 6/29/68		1:25 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTIMORE GENERAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 712 W. Hamburg Street			
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/96	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jack			14. MOTHER'S MAIDEN NAME Annie				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mary Bankins 712 W. Hamburg St.		ADDRESS
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) OVARIAN TUMOR Cerebral Ischemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 6/14/68 19 to 6/29/68 19, that (X) (we) last saw the deceased alive on 6/29/68 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald M. Wood, M.D. OEGREE				23B. DATE SIGNED 7-1-68		23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD, M.D. OEGREE	
23D. ADDRESS S.B.G.H. - 1213 Light Street							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.			

G-630

PO-6835

PO-0000

51-01

72

96

PO-0000

Housewife

U.S.A.

Maryland

Mary Bankins 712 W. Hamburg St.

7/2/68
U.S. Bureau of Census
Washington, D.C. 20540

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SAMUEL MILES

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

6

30

68

11:13 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June

30

1968

11:13 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1631 Pennsylvania Ave. Penn Hotel D.O.A.

6. SEX

Male

7. RACE

Colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4/19/1920

10. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1631 Pennsylvania Ave.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Miles

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Addie McDaniels

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Abbie Todd 10A Casey St. Greenville,
S.C.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cancer of the esophagus
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

13-0X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 1, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/7/68

24C. NAME of CEMETERY or CREMATORY

Greenville

24D. LOCATION

(City, town, or county)

(State)

Greenville, S.C.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 3 1968

Robert E. Fairbanks

Charles A. Rice 661 W. Barre St.

4/12/1920

South Carolina

U.S.A.

George Miles

Abbie McDaniels

Abbie Todd 104 Casey St.
Greenville, S.C.

Greenville

3/7/20

Greenville

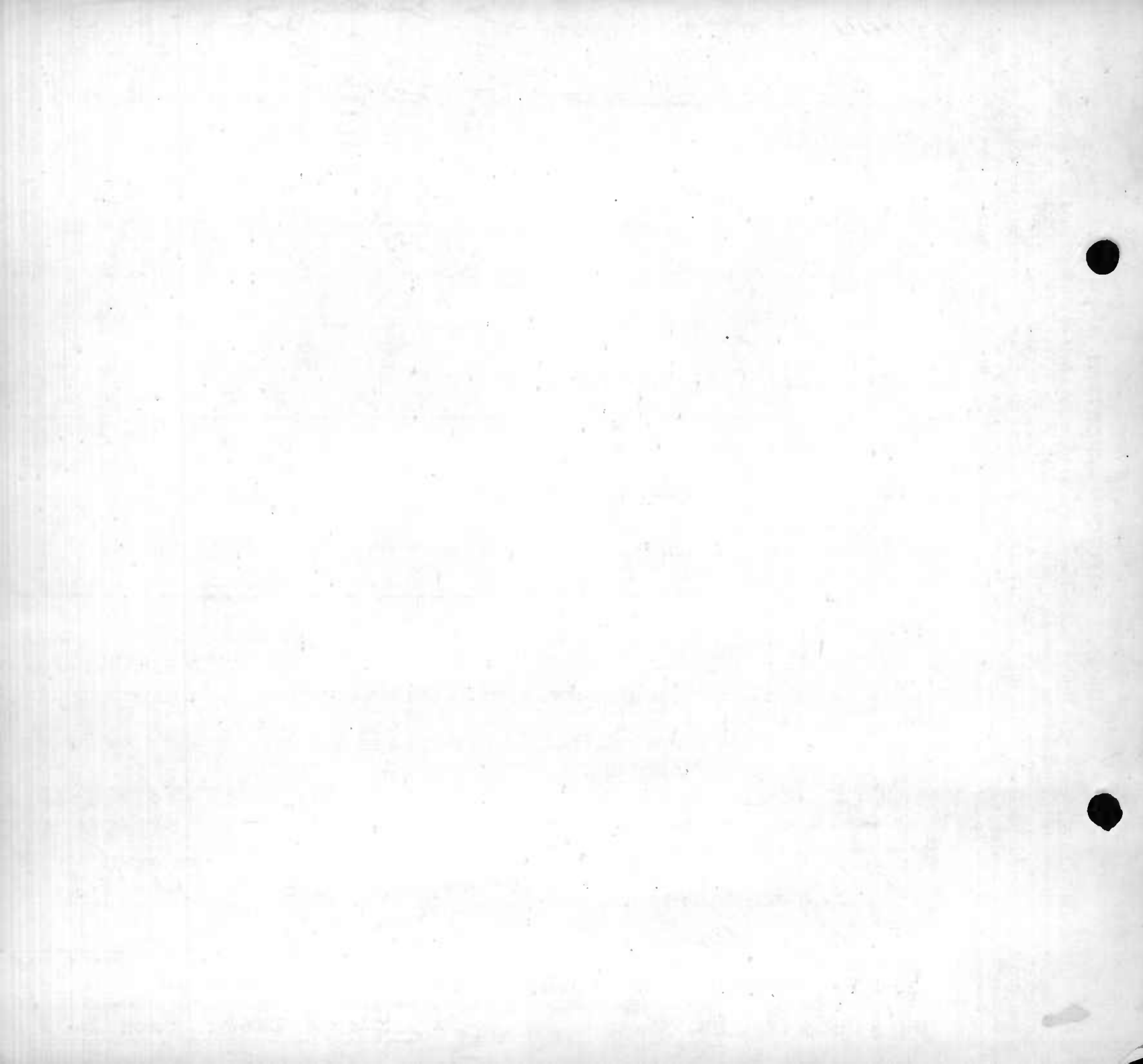
Greenville, S.C.

Charles A. Rice 551 N. Main St.

Released on Approval
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

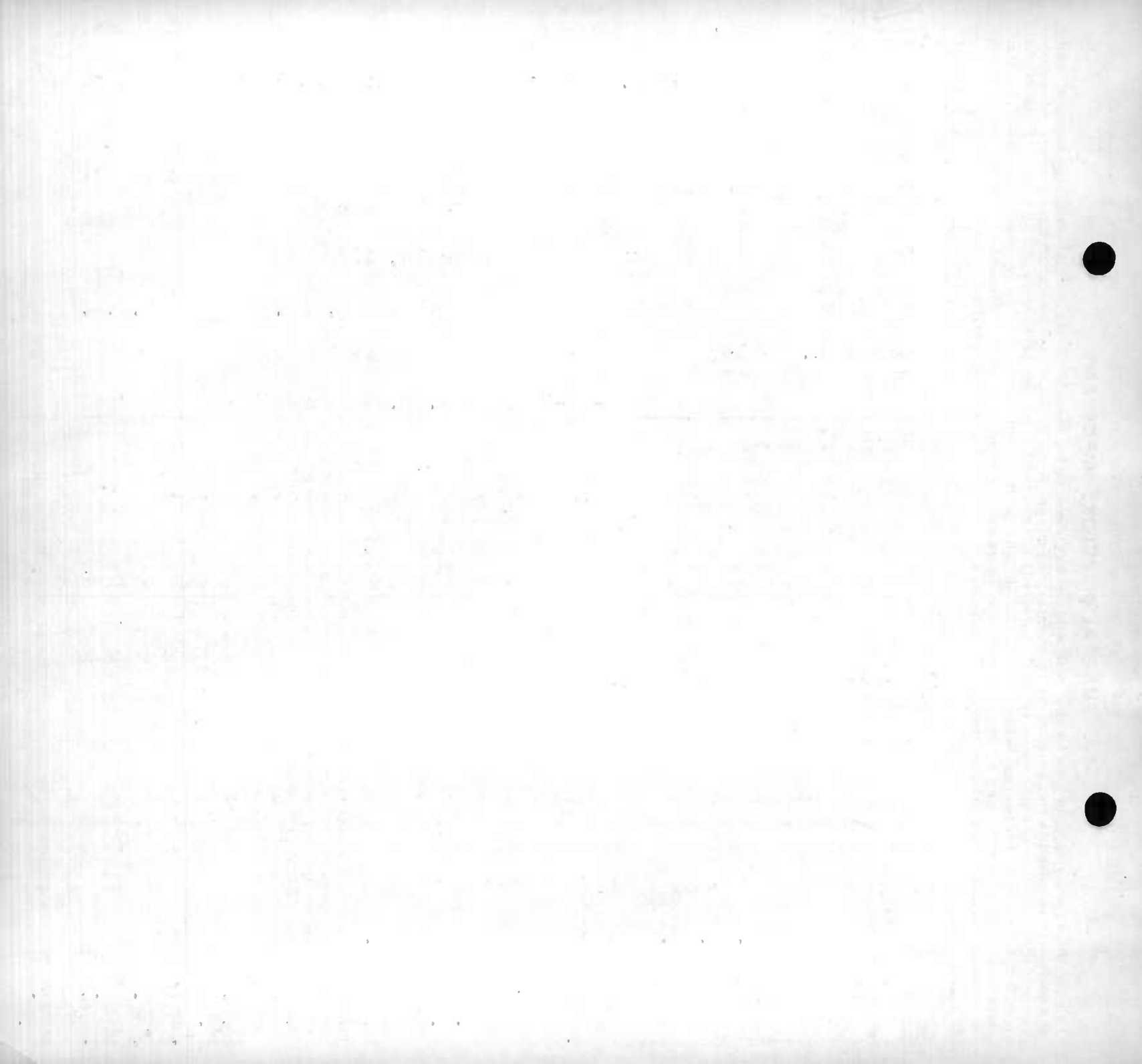
BIRTH NO. H-400		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6834	
1. NAME OF DECEASED (Type or Print) Edna Hall			2. DATE AND HOUR OF DEATH 6/26/68 820 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Univ of Maryland Hosp			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 681 Sarah Ann St 21201		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/25	9. AGE (In years last birthday) 43	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) md.	
13. FATHER'S NAME JAMES JEWES		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART	
18. E870X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BURNS 2°+3° 85%.		25 days	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19A. DATE OF OPERATION 6/1/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BURNS	20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 408 Pine Street 17-03			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 6/1/68 4AM	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? FIRE			
22. I certify that (I) (this hospital) attended the deceased from 6/1 19 68 to 6/26 19 68 , that (I) last saw the deceased alive on 6/26 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Frank Hartman			23B. DATE SIGNED 6/26/68		
23C. PHYSICIAN'S NAME (Type) I. Frank Hartman			23D. ADDRESS Univ. Hosp		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/3/68	24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetry		24D. LOCATION (City, town, or county) (State) A A county Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS A Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

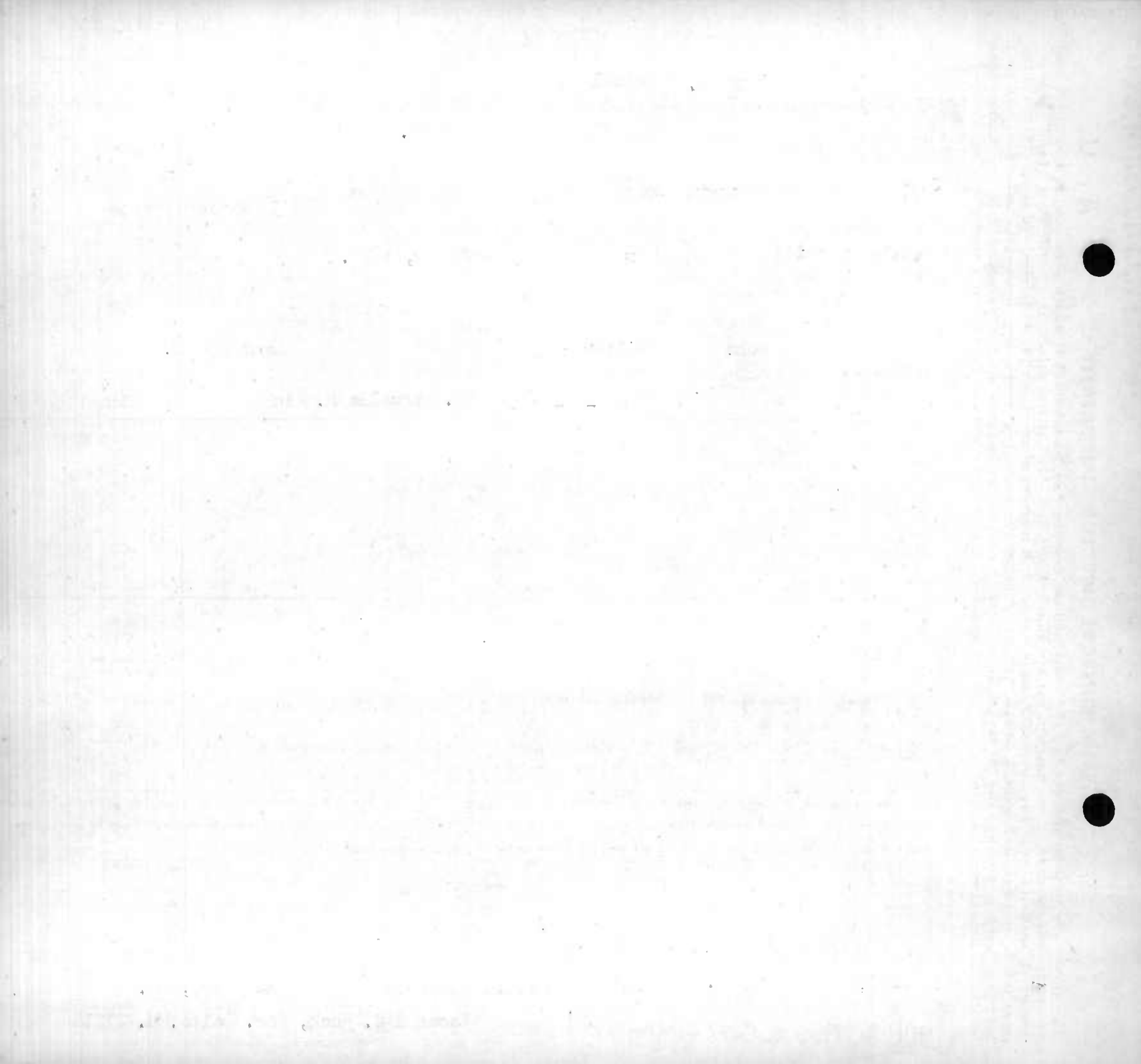
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6835	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Alfred J. Miller		July 2, 1968		Maryland	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. CITY OR TOWN		6. INSIDE CITY LIMITS?	
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. STREET AND NUMBER		8. DATE OF BIRTH		9. AGE (In years last birthday)	
3401 Greenway		June 10, 1880		88	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Consultant		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Decatur H. Miller		Agnes Owens		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
212-03-3885		Mrs. L. Vernon Miller		(Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF:		15 years	
ANTECEDENT CAUSES		(B) DUE TO OR AS A CONSEQUENCE OF:		4 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Terminal Pneumonia		- 3 years	
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
01965		No		Right hip prosthesis 1965	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Aug 7 1967 to July 2, 1968, that (I) last saw the deceased alive on July 2, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
MB Levin MD		July 2, 1968		Dr. M. B. Levin	
23D. ADDRESS		24. BURIAL CREMATION, REMOVAL (Specify)		24C. NAME OF CEMETERY or CREMATORY	
218 E. University Parkway		Burial		Druid Ridge	
24B. DATE		24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.	
7/5/68		Pikesville, Balto. Co., Md.		JUL 5 1968	
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		25C. ADDRESS	
Robert E. Jackson		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

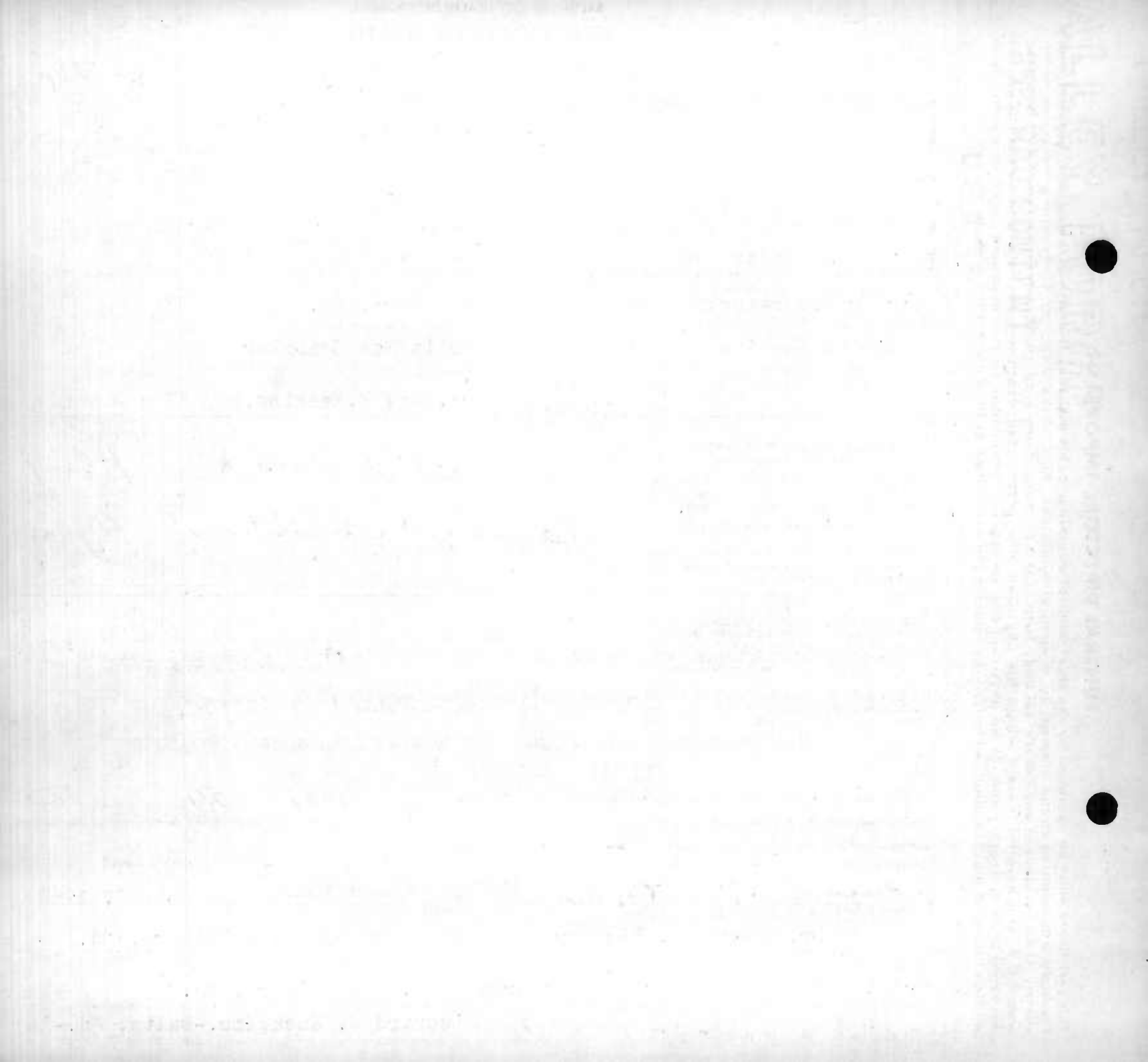
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6836	
<div style="display: flex; justify-content: space-between;"> M-240 68- 6836 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary L. Meisel		July 2, 1968 6 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood Nursing Home			A. STATE Md.		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5803 Oakview Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1878.		9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Miller			14. MOTHER'S MAIDEN NAME Morsella Zinkant		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-0861		17. INFORMANT Mrs. Marcella M. Fink	
				ADDRESS (Same)	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriothrombosis (B) Arteriothrombotic cardiovascular disease (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day					
19. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Dec 16, 1967 to July 2, 1968 , that (I) (we) last saw the deceased alive on June 16, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fredrick J. Vollmer			23B. DATE SIGNED July 2, 1968		
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER M.D.			23D. ADDRESS 6100 YORK RD., BALTIMORE, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68.		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 3 1968		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

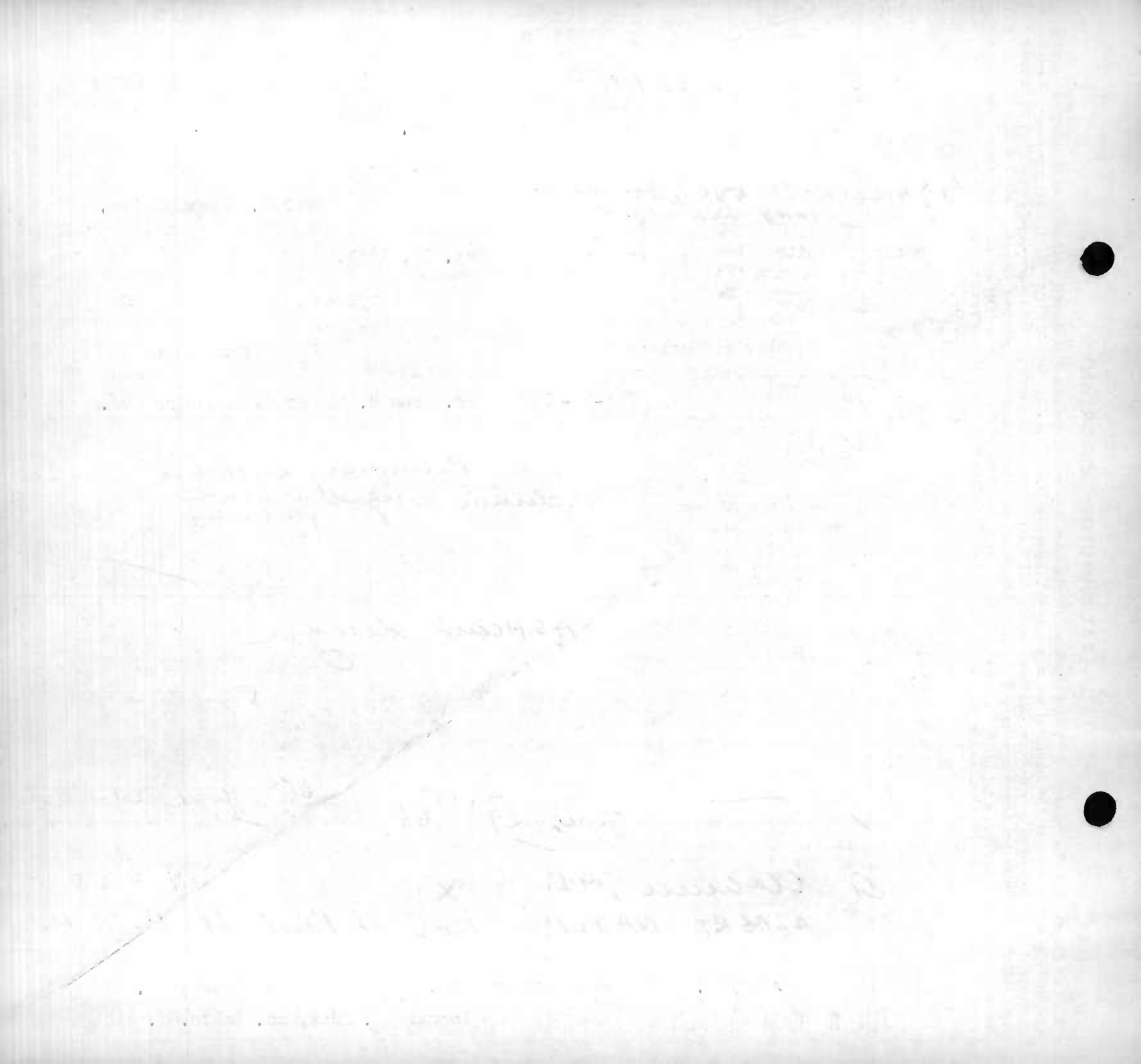
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6837</u>	
<div style="display: flex; justify-content: space-between;"> <u>M-252</u> <u>68- 6837</u> CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<u>AUGUST V. MEEKINS, SR.</u>		<u>July 1, 1968</u> <u>8 30p</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>2901 The Alameda</u>			A. STATE <u>Maryland</u>		
			C. CITY OR TOWN <u>Baltimore</u>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>2901 The Alameda</u>		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
<u>male</u>	<u>caucasian</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>June 1, 1894</u>	<u>74</u>	<u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>interior decorator:retired</u>		<u>retired</u>		<u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>William Meekins</u>			14. MOTHER'S MAIDEN NAME <u>Julia Mae Spangler</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>no</u>		<u>218-01-4023A</u>		<u>Mrs. Edna E. Meekins, 2901 The Alameda</u>	
18. <u>436.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
			(B) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>4 yrs</u>
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> <u>1961</u> to <u>7/1</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>May</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
23A. SIGNATURE <u>Conrad L. Richter MS</u>				23B. DATE SIGNED <u>July 2, 1968</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Conrad L. Richter</u>				23D. ADDRESS <u>3128 Harford Rd, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>burial</u>		<u>7/5/68</u>		<u>Moreland Memorial Cem.</u>	
				<u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>JUL 5 1968</u>		<u>Robert E. Talbott</u>		<u>Leonard J. Ruck, Inc.-Balto, Md.-14</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6838	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>JULIA C. LENHOFF</i>		2. DATE AND HOUR OF DEATH <i>7.2.68</i> <i>10.55 A</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>70 HILLCREST NURSING HOME</i> <i>212 STONY RUN AVE</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____ C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>702 N. Lakewood Ave.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 19, 1883.</i>		9. AGE (In years last birthday) <i>84</i> If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Charles Deckwar</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Duggan</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>218-32-1799</i>		17. INFORMANT ADDRESS <i>Mr. John H. Limmer, 1224 Spring Ave.</i>			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <i>Pulmonary embolism</i> <i>chronic congestive heart failure</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>AS Heart disease</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>AS Heart disease</i>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>5.15</i> 19 <i>68</i> to <i>June 29</i> 19 <i>68</i>, that (I) (we) last saw the deceased alive on <i>June 29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Mahum, M.D.</i>				23B. DATE SIGNED <i>7.2.68</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALBERT NAHUM</i>				23D. ADDRESS <i>1202 St. Paul St. Balto, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 3 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>			



FUNERAL DIRECTOR: IMPORTANT

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W-420		68- 6839		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6839		
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MRS. KATIE WILLS				
2. DATE AND HOUR OF DEATH June 29, 1968 12:20 P.M.								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Church Home & Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY Balto. C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hosp.				E. STREET AND NUMBER 103 Willow Spring Rd.				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/95	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Jackson		14. MOTHER'S MAIDEN NAME Nancy Lowery		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. JOHN CREIGHTON-103 WILLOW SPRING				ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hepatic Failure sec. to cirrhosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bleeding Esophageal varices				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				Days
(C) DUE TO, OR AS A CONSEQUENCE OF:								
19. DATE OF OPERATION 5/21/68				20. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21A. ACIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 25, 1968 to May 29, 1968 , that (I) (we) last saw the deceased alive on May 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE Francisco Baltazar				23B. DATE SIGNED 6/29/68				
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTASAR MD				23D. ADDRESS Church Home & Hosp Balto 31, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) COLGATE MD		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME DUNDOWN				
				ADDRESS				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6840
B-350 68-6840		CERTIFICATE OF DEATH		
BIRTH NO. <u>1</u>		2. DATE AND HOUR OF DEATH <u>1-35 am 7/3/68</u> <u>1-35 A.</u> M.		
1. NAME OF DECEASED (Type or Print) <u>BATTEN, RUTH M. MRS.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home & Hospital.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>217 COLGATE AVE</u> <u>53-00</u>		
5. SEX <u>Female</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1911</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri USA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>—</u>
13. FATHER'S NAME <u>WILLIAM CUMMINGS</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA BULLOCK</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) fill yes, give war or dates of service <u>—</u>		16. SOCIAL SECURITY NO. <u>431-24-8808</u>	17. INFORMANT ADDRESS <u>CHAS. WREN- 217 COLGATE AVE</u>	
18. <u>340.0</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Diffuse Peritonitis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ruptured Appendix</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>x few days</u> <u>few days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>550.1</u>				
19A. DATE OF OPERATION <u>6/24/68 & 6/30/68</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Peritonitis, Ruptured Appendix</u>	20A. AUTOPSY? (Yes or No) <u>Yes.</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>6/21/1968</u> to <u>7/3/1968</u> , that (I) (we) last saw the deceased alive on <u>7/3/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Krishna Reddy MD.</u>		23B. DATE SIGNED <u>7/3/68</u>		
23C. PHYSICIAN'S NAME (Type) <u>KRISHNA REDDY</u>		23D. ADDRESS <u>100 N. Broadway, Baltimore MD 21231</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>7/5/68</u>	24C. NAME of CEMETERY or CREMATORY <u>EDGEWOOD CEMETERY</u>	24D. LOCATION (City, town, or county) (State) <u>NORTH LITTLE ROCK ARK.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1968</u>	25B. NAME OF REGISTRAR <u>Paul E. Fairbank</u>	25C. FUNERAL DIRECTOR ADDRESS <u>VOLKHA FUNERAL HOME DUNDALK MD</u>		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6841
F-200 68-6841		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)		July 3, 1968 M.		
George Gerard Fuchs				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		
114 N. Belnord Ave.		C. CITY OR TOWN D. INSIDE CITY LIMITS?		
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
		114 N. Belnord Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7-20-1892	75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Printer				Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Conrad Fuchs		Anna C. Preller		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
yes WW-1		213-03-7250		Mrs. Helen Scandora 813 Mildred Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		Malignant tumor of brain 1 yr.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
193.0 II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
Dec. 1967		Malignant tumor of brain		NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from April 18, 1968 to July 3, 1968, that (I) (we) last saw the deceased alive on July 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
I. T. FEINGLOS, M.D.		7/5/68		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
I. T. FEINGLOS, M.D.		2007 I. Ratt St. Balt. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		7-6-68		Sacred Heart Cemetery
				24D. LOCATION (City, town, or county) (State)
				Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JUL 5 1968		Robert E. Fuchs		B. Dabrowski 2818 E. Baltimore St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-550 68-6842		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68-6842	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HAZEL Norris SHANNAHAN		JULY 1, 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 582 W. University Pkwy.		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1889	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dr. John D. Norris		14. MOTHER'S MAIDEN NAME Mollie Warfield	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. unkn.		17. INFORMANT John G. Shannahan, Sr.	
				ADDRESS Same	
1B. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Generalized art-sclerosis DUE TO, OR AS A CONSEQUENCE OF: (B) Art-sclerotic heart dis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? yrs.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.0 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1965 to June 1968, that (I) (we) lost saw the deceased olive on June 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nathan Herman				23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) Dr. Nathan Herman				23D. ADDRESS 5510 Roland Ave. Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Spring Hill	
24D. LOCATION Easton, Md.		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Maurice Newman & Son	
				ADDRESS Easton, Md.	

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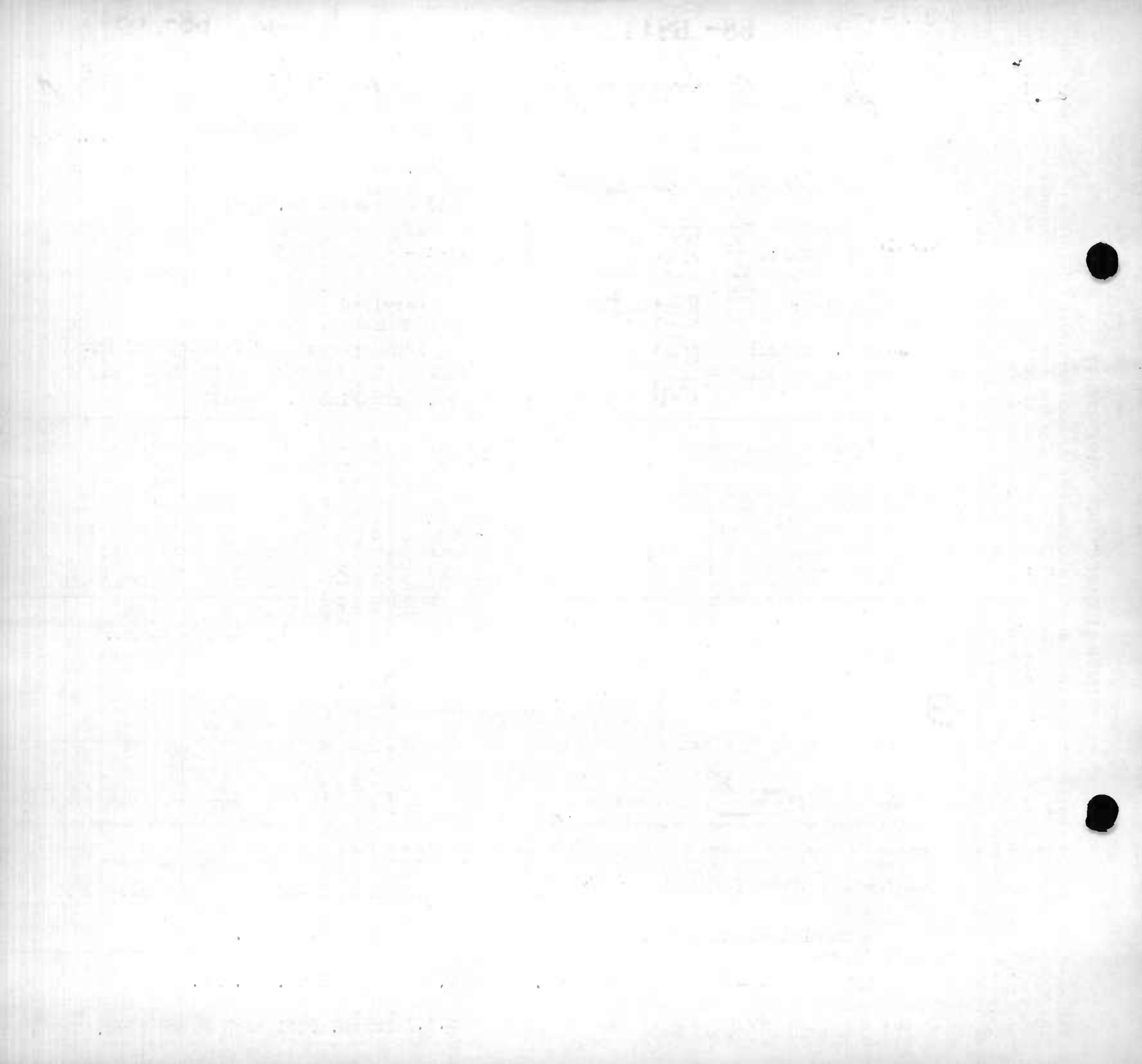
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FUNERAL DIRECTOR: IMPORTANT

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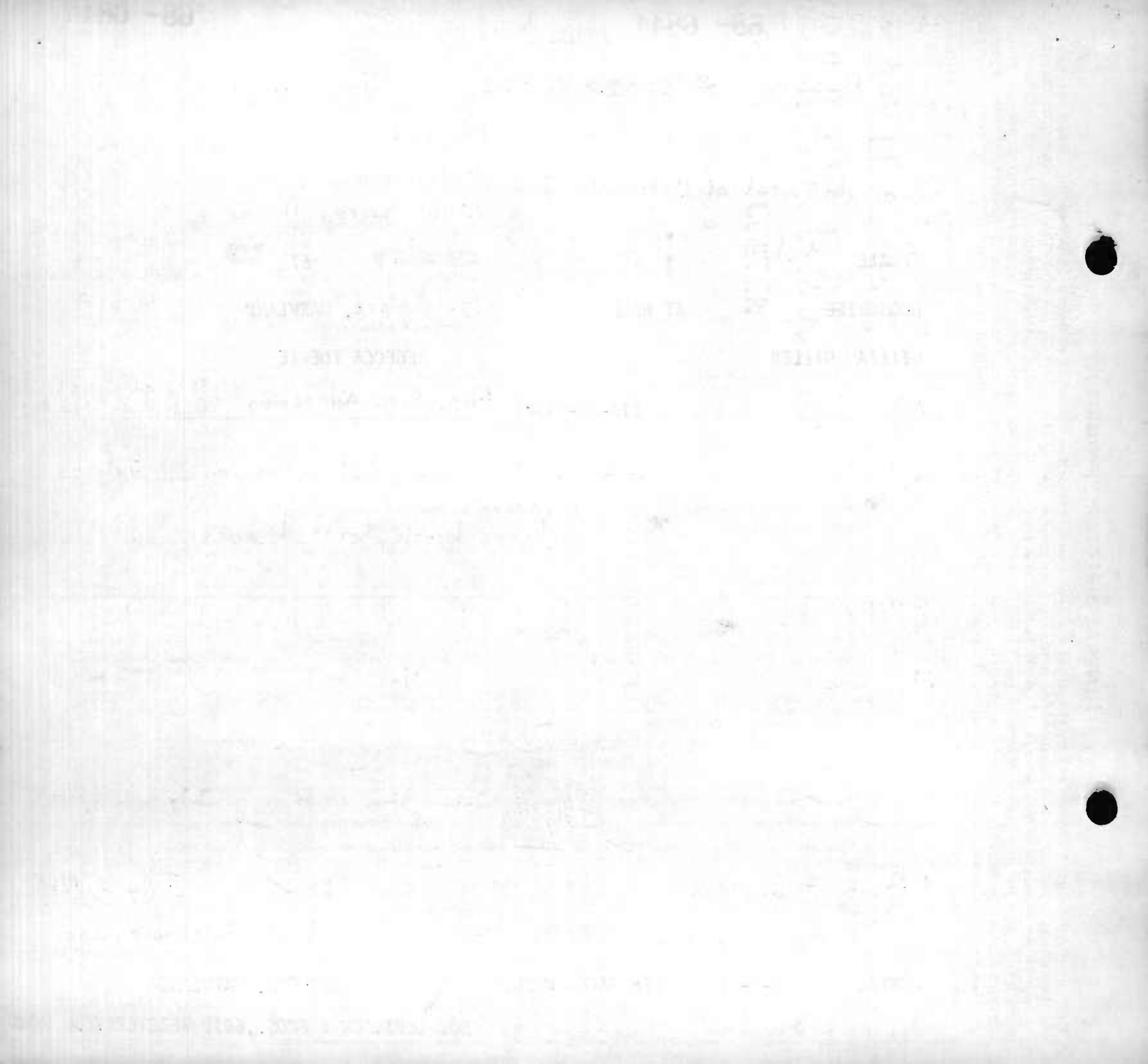
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6843
G-254		68- 6843		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John R. Gosnell Jr</i>		2. DATE AND HOUR OF DEATH <i>6-30-68</i> <i>8 30 A M.</i>	
3. PLACE IN <i>Baltimore, Maryland, WHERE PRONOUNCED DEAD</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto. 34</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>7917 Dalesford Rd. (34)</i>	
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-11-04</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cotton Mill</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John W. Gosnell</i>		14. MOTHER'S MAIDEN NAME <i>Ida Magness 7917 Dalesford Rd. (34)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213 03 3049</i>		17. INFORMANT <i>Mrs. Catherine A. Gosnell</i>	
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Congestive Heart Failure</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes mellitus</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) <i>Polycythemia 2° to Chr. Lung Disease</i>					
19A. DATE OF OPERATION <i>260 X II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-27-1968</i> to <i>6-30-1968</i> , that (I) (we) lost saw the deceased alive on <i>6-30-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nathaniel Aikens-Afful, M.D.</i>		23B. DATE SIGNED <i>6-30-68</i>		23C. PHYSICIAN'S NAME (Type) <i>Nathaniel Aikens Afful</i>	
23D. ADDRESS <i>Mercy Hospital, Balto.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-3-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Moreland Me. Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. E. Johnson, 8521 Loch Raven Blvd. 21204</i>		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-432 68-6844		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6844
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Bessie [REDACTED] GOLDSTINE		2. DATE AND HOUR OF DEATH July 2, 1968 3:15 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital of Baltimore Inc.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 7046 Surrey Drive				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH [REDACTED]	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Baltimore, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME WILLIAM MILLER		14. MOTHER'S MAIDEN NAME REBECCA TUERKE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-30-9402		17. INFORMANT Mrs. Rita Klotzman
				ADDRESS 3513 Old Court Road Baltimore, Md #08
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: hypertensive (B) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: (C) none		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II				
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -
22. I certify that AT (this hospital) attended the deceased from June 22, 1968 to July 2, 1968 , that (I) (we) last saw the deceased alive on July 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Barry Green, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 2, 1968
23C. PHYSICIAN'S NAME (Type) Barry Green, M.D.		23D. ADDRESS Sinai Hospital of Baltimore, Inc.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7-3-68	24C. NAME of CEMETERY or CREMATORY BETH JACOB VESHEAR		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. [REDACTED]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68- 6845
C-550 68- 6845			CERTIFICATE OF DEATH		
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) I. TERESA M. CONEN			JULY 2, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3014 Virginia Avenue Baltimore, Maryland 21215			A. STATE New Jersey		
			B. COUNTY V-27		
C. CITY OR TOWN North Bergen			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 327 78th Street					
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1897	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10B. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Conen			14. MOTHER'S MAIDEN NAME Rosella Blassey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 140 32 9659	17. INFORMANT Mrs. Barbara J. Judge ADDRESS 21043 Amherst Avenue		
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC HEART DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.0 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from JUNE 15, 1968 to JULY 2, 1968 , that (I) (we) last saw the deceased alive on JUNE 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein			Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/2/68
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN			23D. ADDRESS 6001 PARK HEIGHTS AVE BALTO, MD		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 6, 1968	24C. NAME OF CEMETERY or CREMATORY Holy Name Cemetery		24D. LOCATION (City, town, or county) (State) New Jersey	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR D. C. A. J. O. R.		25C. FUNERAL DIRECTOR Brennan Funeral Home 6414 Bergenline Ave.	

John J. ...
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Jan. 11, 1937

Female

Education

New York

John J. ...

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5-530 68-6846 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6846

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 30 68 4:40 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30 1968 4:40 p M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Ft. Meade Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Dec. 13, 1920	10. AGE (In years lost birthday) 47	11. BIRTHPLACE (State or foreign country) Virginia		E. STREET AND NUMBER 8033-B Evans Ct. 52-00	
12. CITIZEN OF USA		13. FATHER'S NAME James A. Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	
15. MOTHER'S MAIDEN NAME Lucy Stacy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 230-30-2413	
18. INFORMANT Mrs. Thelma Smith		ADDRESS Charlestown, Md.		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E985X Cerebrovascular injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E936.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 8033-B Evans Ct.	
22D. TIME OF INJURY (APPROX.) ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found lying on bottom of stair	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, both in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE: Edward F. Wilson, M.D. EXAMINER'S NAME (Type): Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: July 1, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Charlestown Cemetery	
24D. LOCATION (City, town, or county) (State) Charlestown Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Farley, Jr.	
25C. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6847
<div style="font-size: 2em; font-weight: bold;">R-100</div> <div style="font-size: 1.5em; font-weight: bold;">68- 6847</div>		CERTIFICATE OF DEATH		
BIRTH MO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		RAAB, JOSEPH GREGORY SR.		July 1, 1968 10:15 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutional: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 1.5em; font-weight: bold;">23</div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		A. STATE Maryland B. COUNTY		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2910 Erdman Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-20	9. AGE (In years lost birthday) 47
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckdriver, Milk.		10B. KIND OF BUSINESS OR INDUSTRY Milk Sealtest	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gregory Raab		14. MOTHER'S MAIDEN NAME Elizabeth Buer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-20-45 To 12-30-46		16. SOCIAL SECURITY NO. 215-14-8741	17. INFORMANT Records ADDRESS VAH, Balto., Md. 3900 Loch Raven Blvd.	
18. 470.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease (B) DUE TO, OR AS A CONSEQUENCE OF: several yrs (C)				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 420.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that we (this hospital) attended the deceased from June 27 19 68 to July 1 19 68 , that we last saw the deceased alive on July 1 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Susan Howard Mather M.D.</i>		23B. DATE SIGNED July 2, 1968		23C. PHYSICIAN'S NAME (Type) SUSAN HOWARD MATHER, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUL 5 1968		
24F. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24G. FUNERAL DIRECTOR John J. Duda		
24H. ADDRESS 7922 Wise Ave. Dundalk, Md.				

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. X	68- 6848
17-220		68- 6848		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MC HUGH, MARGARET ANN			JUNE 30, 1968 6:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSP. CATON & WILKENS AVE BALTO MD 21229			A. STATE MARYLAND		
			B. COUNTY BALTO Co. 53-00		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 603 HILLTOP AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-85	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: It Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME FRANK			14. MOTHER'S MAIDEN NAME MARGARET (KRUGER)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	17. INFORMANT ST AGNES RECORDS-BALTO MD 21229		
18. 427.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH PROBABLE BRONCHIAL BRONCHO- PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 434.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 27</u> 19 <u>68</u> to <u>JUNE 30</u> 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JUNE 30</u> 19 <u>68</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE 			23B. DATE SIGNED 06 30 68		23C. PHYSICIAN'S NAME (Type) R. REVILLA
23D. ADDRESS ST AGNES HOSPITAL-CATON & WILKENS AVE BALTO MD 21229			23E. DATE SIGNED 06 30 68		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-3-68	24C. NAME OF CEMETERY or CREMATORY Woodlawn Cems.	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	25B. NAME OF REGISTRAR Robert E. Farley	25C. FUNERAL DIRECTOR Farley, Carmichael & Co. - Catonsville, Md.			

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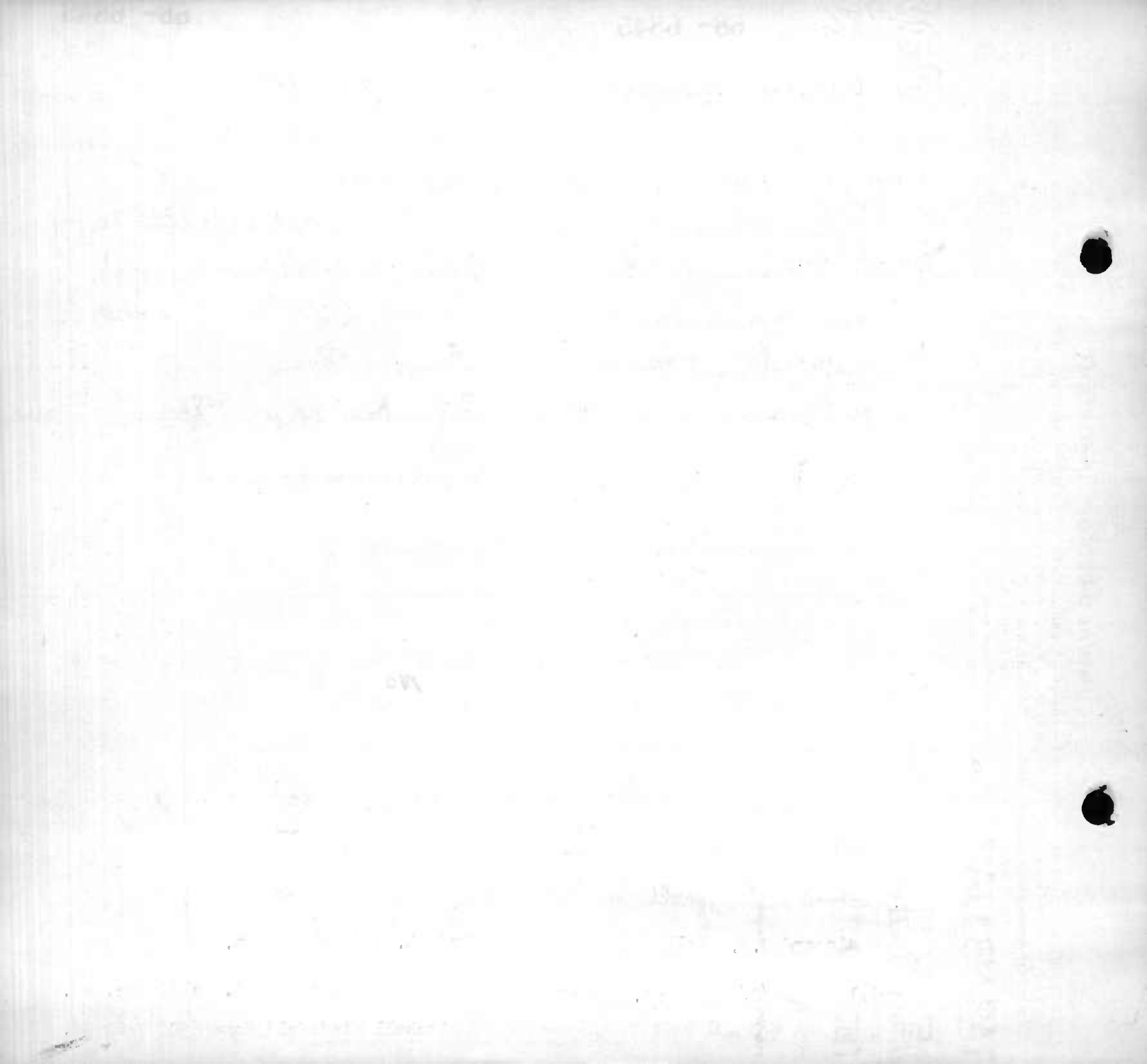
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-126 68-6849				BALTIMORE CITY HEALTH DEPARTMENT		68-6849	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MR GARLAND ABSCHER				July 1/68 0930			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL				A. STATE MD BALD CITY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE			
44				D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE				6. RACE CAUL			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH SEPT 13, 1889			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (In years last birthday) 78			
10B. KIND OF BUSINESS OR INDUSTRY NONE				11. BIRTHPLACE (State or foreign country) NORTH CAROLINA			
13. FATHER'S NAME UNKNOWN				12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
16. SOCIAL SECURITY NO. UNK				17. INFORMANT G. L. LOCHMEYER			
				ADDRESS 3020 MOUNTAIN STREET			
18. 4309 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PROLONGED SUBARACHNOID HEMORRHAGE (B) _____ (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 330X II NONE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-30-68 1968 to 7-1-1968, that (I) (we) last saw the deceased alive on 6/30/68 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard C.W. Yall M.D.				23B. DATE SIGNED 7/1/68			
23C. PHYSICIAN'S NAME (Type) Richard C.W. Yall				23D. ADDRESS 33rd St. and Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Old Donnel St. Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6850
H-220 68-6850		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOULA HUGHES (Mrs)		2. DATE AND HOUR OF DEATH 7/1/68 6:25 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/20/92 9. AGE (In years lost birthday) 75 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME William W. Farnadis		14. MOTHER'S MAIDEN NAME Emma Berg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Sister Mrs Elizabeth Robson ADDRESS Same as Deceased
18. 796.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral edema of liver (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Hepatitis - Pulmonary Edema - (C) Multiple Metastasis -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CS.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from 6/30/1968 to 7/1/1968 , and that (I) the last saw the deceased alive on 6/30/1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) the (did) (did not) view the body after death.				
23A. SIGNATURE Dermot Campbell M.B.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/1/68
23C. PHYSICIAN'S NAME (Type) DERMOT CAMPBELL M.B.		23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Green Mount
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd., Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-500 68-6851		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6851	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM J. DUNN		1 JULY 1968 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
44 UNION MEMORIAL HOSPITAL			MARYLAND BALTIMORE CITY		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER, ZIP		
			636 COKEBURY AVE, ZIP 21218		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/16/97	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Custodian		Balto City		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Patrick Dunn			Mary Gannon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WW-1		213010237 Miss Johanna Bruns-636 Cokesbury	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
486 X 17250.9			PNEUMONIA		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			? TUBERCULOSIS		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			PULMONARY EDEMA.		
			(C) DIABETES MELLITUS		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1 JULY 1968 to 1 JULY 1968, that (I) (we) last saw the deceased alive on 1 JULY 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Print)
PARK W. ESPENSCHADE JR. M.D.			1 JULY 1968		HOUSE STAFF
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial			7/5/68		Cathedral Cem.
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JUL 5 1968			Robert E. Fairbank		Mitchell-Wiedefeld Home 6500 York Rd-21212

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O-520 68-6852 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68-6852

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCIS OWENS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 1 68 8:25a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 103 W. Monument St. 3rd floor		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1 1968 8:25a M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Aug 9 1892		10. AGE (In years lost birthday) 74 75	E. STREET AND NUMBER 103 W. Monument St.		
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME F. H. Owens		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		14B. KIND OF BUSINESS OR INDUSTRY Space	15. MOTHER'S MAIDEN NAME Jessie ??		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-26-5091	18. INFORMANT Mrs. Patti M. Owens		ADDRESS Same
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
20A. DATE OF OPERATION 7-22-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. DATE SIGNED July 1, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1968		24C. NAME OF CEMETERY or CREMATORY Washington Cem.	
24D. LOCATION (City, town, or county) (State) Washington, Pa.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. Balto., Md. 21202			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6853	
<div style="display: flex; justify-content: space-between;"> K-530 68-6853 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Jessie Kennedy			2. DATE AND HOUR OF DEATH July 2, 1968 3:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 90			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ADDRESS OR LOCATION 1105 E. Fayette Street			E. STREET AND NUMBER 2018 St. Paul Street		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1980	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Marietta, Ga.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME R. W. McClenton			14. MOTHER'S MAIDEN NAME Martha Norton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 05 7842D	17. INFORMANT Jessie Seidman ADDRESS 5503 Rusk Avenue		
18. 1988 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of Breast			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Carcinoma			5 yrs.		
170 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD			10yrs		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the physician) attended the deceased from June 22, 1968 to July 2, 1968 , that (I) did last saw the deceased alive on July 2, 1968 and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) did (did) view view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED July 2, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. E. Ellsworth Cook				23D. ADDRESS 2431 Maryland Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-5-1968	24C. NAME of CEMETERY or CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook & Brooks, Inc. Balto., Md. 21202	

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B-160 68-6854 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-6854

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) GEORGE BEAVER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> JULY Day Year Hour Estimated <input type="checkbox"/> 3, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Hospital (DOA)		3. DATE PRONOUNCED DEAD JULY 3, 1968 Day Year Hour 9:32 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Apr 5, 1902		10. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W Beaver		14. MOTHER'S MAIDEN NAME Flora Leitner	
15. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Family		ADDRESS Same	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 4, 1968 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem		24D. LOCATION (City, town, or county) (State) AA Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR McElly F.H.		ADDRESS 2122 25	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68-6855</u>
BIRTH NO. <u>5-550 68-6855</u>				CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) <u>Schuman, Viola Mae</u>		2. DATE AND HOUR OF DEATH <u>6/30/68</u> <u>4</u> <u>P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bolton Hill Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/14/99</u>	9. AGE (In years last birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fancy stitcher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Shoe Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>BAKEE Joseph</u>		14. MOTHER'S MAIDEN NAME <u>ROBINETTE, Marie</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-9113A</u>		17. INFORMANT <u>Mrs. Frances Wolfe</u>
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Rigor Lower Lobe Pneumonia</u>		ADDRESS <u>115 Cedarmere Rd. Owings Mills, Md.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ABCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>422.1 II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12 June 1968</u> to <u>30 June 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>30 June 1968</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A.C. Alevizatos, M.D.</u>		23B. DATE SIGNED <u>30 June 68</u>		23C. PHYSICIAN'S NAME (Type) <u>A.C. ALEVIZATOS, M.D.</u>
23D. ADDRESS <u>1209 ST. Paul St. Balto 3, Md.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>July 3, 1968</u>		24C. NAME OF CEMETERY or CREMATORY <u>Evergreen Mem. Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Finksburg, Carroll, Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>		25C. FUNERAL DIRECTOR ADDRESS <u>J. J. Eckhardt Owings Mills, Md.</u>

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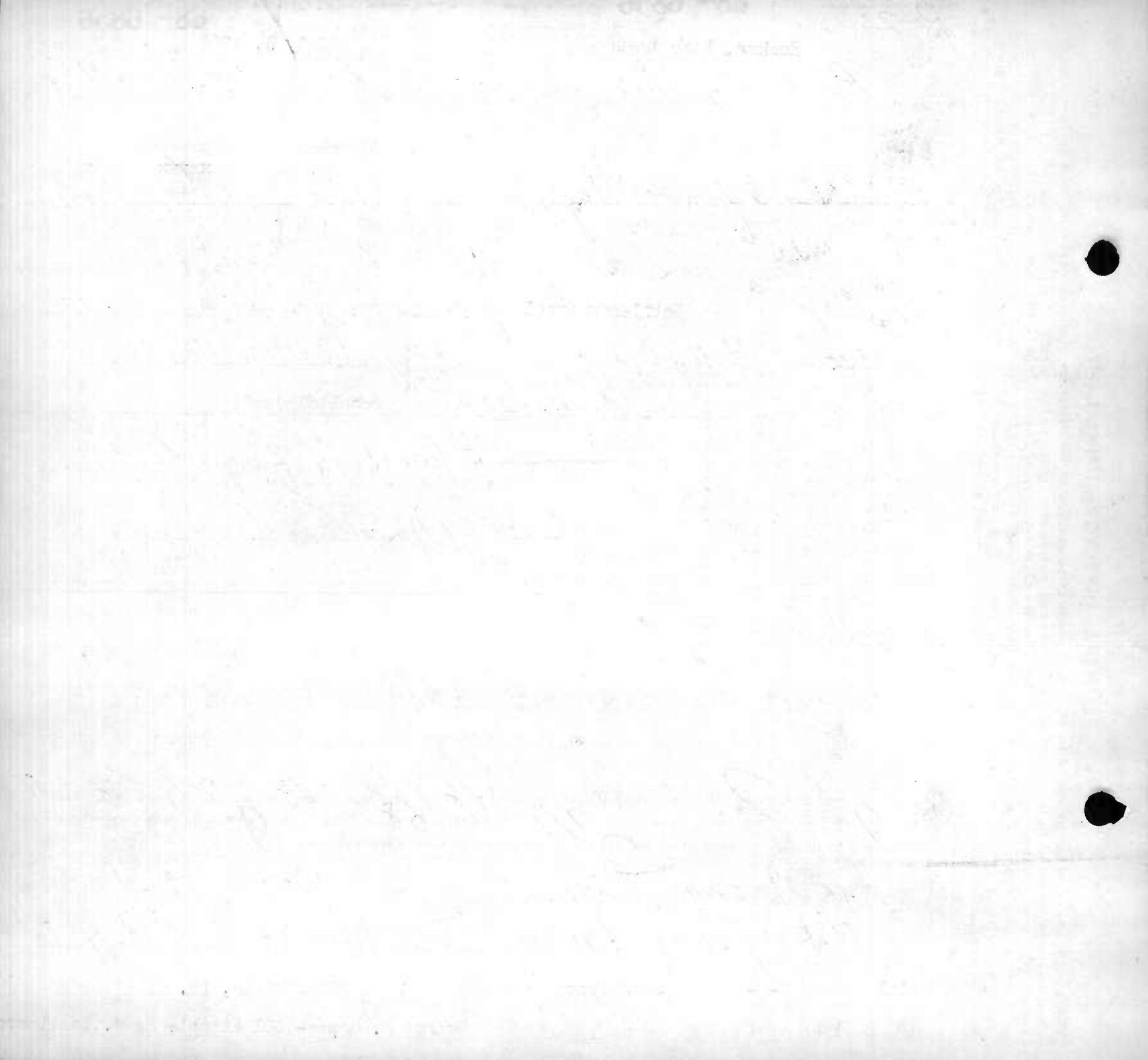
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6856
R-260 BIRTH NO. Rucker, Lucy Adeline 1. NAME OF DECEASED (Type or Print) Rucker, Lucy Adeline		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH July 1, 1968 6:40PM 7-1-68 6:40P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6 Franklin Square Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY A.A.C. 52-00 C. CITY OR TOWN Suburban Baltimore D. INSIDE CITY LIMITS? NO E. STREET AND NUMBER 5301 Brookwood Road 25		
5. SEX F 6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/17	9. AGE (In years last birthday) 50 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Caesar Buglia 14. MOTHER'S MAIDEN NAME Stefanie De Pauli		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 166-12-2398		17. INFORMANT ADDRESS Hospital Chart
CAUSE OF DEATH				
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bleeding from the tumor		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma larynx		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 161X		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/8/68 19 68 to 7/1/68 19 68 , that (I) (we) last saw the deceased alive on 7/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Nat Joong Im		23B. DATE SIGNED 7-1-68		23C. PHYSICIAN'S NAME (Type) Nat Joong Im
23D. ADDRESS Franklin Square Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-5-1968		24C. NAME OF CEMETERY OR CREMATORY Mount Peace Cemetery		24D. LOCATION (City, town, or county) (State) Minersville, Pa.
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hgwy., Baltimore

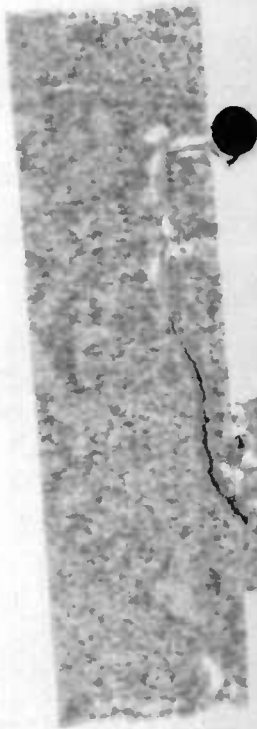


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530		68-6857		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6857	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) SMITH, Ethel E.			
2. DATE AND HOUR OF DEATH June 28, 1968 12:30 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Pennsylvania V-35			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Haverford		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER N. Rose Lane				B. DATE OF BIRTH 8-27-1894		9. AGE (In years lost birthday) 72	
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-1-18 to 5-31-20		16. SOCIAL SECURITY NO. 217-54-8379		17. INFORMANT Records V. A. Hospital, Baltimore, Md. 21218 ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ASCVD, generalized, marked of coronary arteries Fracture of right hip		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? Years 9 Days			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) 6-20-68		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? Rm. 4. Hosp		(If in Baltimore City, give exact location)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell to floor					
22. I certify that (X) (this hospital) attended the deceased from June 20, 1968 to June 28, 1968, that (X) (we) last saw the deceased alive on June 28, 1968 and that in (X) (my) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE NB Bayadi				23B. DATE SIGNED 6-30-68		23C. PHYSICIAN'S NAME (Type) Nagui R. El-Bayadi, M. D.	
24A. BURIAL CREATION, REMOVAL, ETC. BURIAL		24B. DATE 7-3-68		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS		24D. LOCATION (City, town, or county) (State) YADEN DEL. CO. PA.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR R. E. F. Adams		25C. FUNERAL DIRECTOR Wm. J. Schenck & Sons Baltimore		25D. ADDRESS	

10-1-1941



Wm. A. [illegible]
10-1-1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 0-650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68-6858	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MABEL OREM		2. DATE AND HOUR OF DEATH June 28, 1968			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. CITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY Balt Co. 53-00 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 7537 Berkshire Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/23/04	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Toby Mfg. Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Peeples			
14. MOTHER'S MAIDEN NAME Florence Stauffner		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Ira J. Orem - 7537 Berkshire Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.3 I Arteriosclerotic heart disease, coronary artery blockage		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH app 18 hrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 420.1 II			
21A. DATE OF OPERATION		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21G. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-13-64 to 6-28-68 and that (I) (we) last saw the deceased alive on 6-7-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George C. Lovett		23B. DATE SIGNED 6-28-68		23C. PHYSICIAN'S NAME (Type) George C. Lovett	
23D. ADDRESS 100 N Broadway		23E. M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem.	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Austin E. Donovan-3818 Roland Ave.	
25D. ADDRESS		25E. (City, town, or county)			

1000-100

1000-100

1000-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6859	
<div style="display: flex; justify-content: space-between;"> W-416 68- 6859 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Norma C. Walpert</i>		2. DATE AND HOUR OF DEATH <i>6-30-68</i> <i>8 30</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <i>Maryland</i>		B. COUNTY
			C. CITY OR TOWN <i>Baltimore</i>		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		<i>25-31</i>
			E. STREET AND NUMBER <i>404 Hazlett Ave</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/24/19</i>	9. AGE (In years last birthday) <i>48</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Office Medical Examiner's</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Edgar Kirby</i>			14. MOTHER'S MAIDEN NAME <i>Sherry</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212 36 8275</i>		17. INFORMANT <i>Mrs Carol S. O'Neil-404 Hazlett Ave-21229</i>	
18. <i>5-30-1</i> <i>15250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Acute mediastinitis and aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic esophagitis with stricture and ulceration.</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>months</i> <i>years</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes Mellitus</i>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>she</i> (this hospital) attended the deceased from <i>6-28</i> 19 <i>68</i> to <i>6-30</i> 19 <i>68</i> , that <i>she</i> (we) last saw the deceased alive on <i>6-30</i> 19 <i>68</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>she</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Mehdi Sarkarati</i>				23B. DATE SIGNED <i>6-30-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>Mehdi Sarkarati</i>				23D. ADDRESS <i>Bon Secours Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-3-1968</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. John's Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Howard County Maryland.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Mac Mink</i> ADDRESS <i>301 Frederick Rd. 21228</i>	

United States

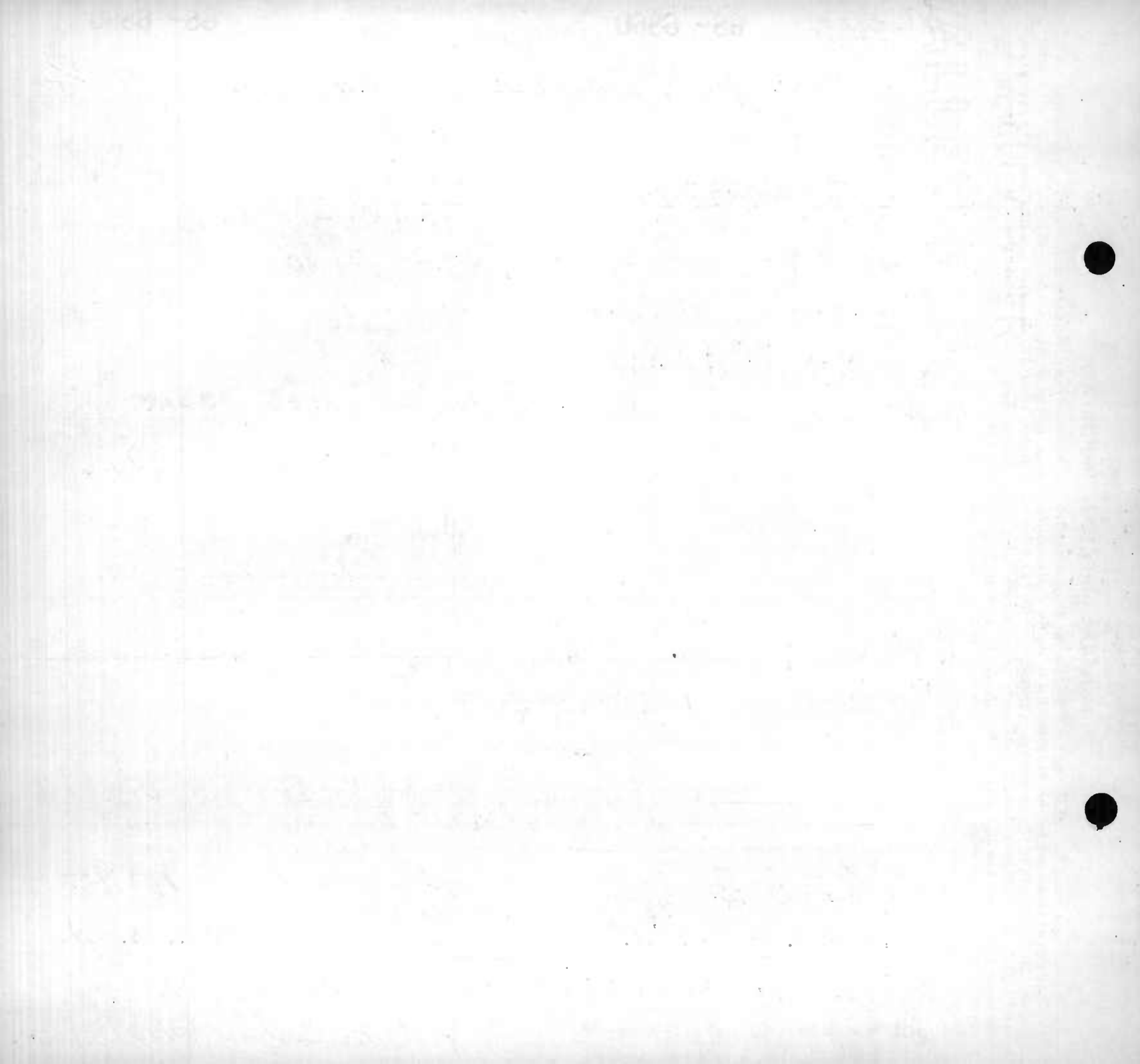
1910

THE UNITED STATES OF AMERICA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

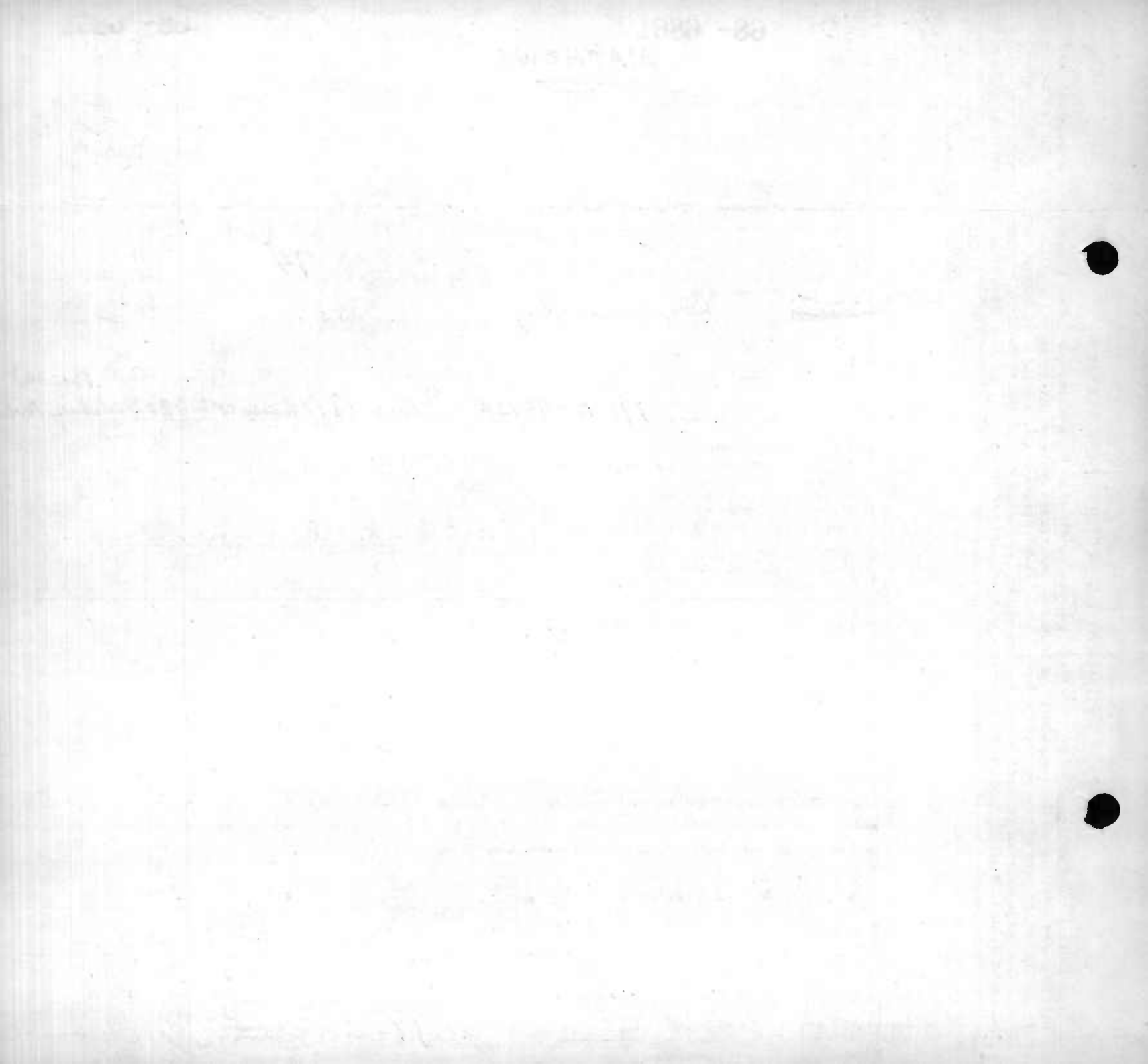
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6860	
M-235 68-6860		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARY A. McDONNELL	
2. DATE AND HOUR OF DEATH JUNE 30, 1968		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 223 W. 29th ST.		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 223 W. 29th ST.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		11. BIRTHPLACE (State or foreign country) IRELAND	
10B. KIND OF BUSINESS OR INDUSTRY AT HOME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS McKOWNE		14. MOTHER'S MAIDEN NAME NORA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. B 213-10-0207	
17. INFORMANT Mrs. Mary Turbett		ADDRESS SAME	
18. 4379 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(B) Infection DUE TO OR AS A CONSEQUENCE OF: years	
(C) Antisclerotic Cardiovascular Disease years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 334X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1, 1958 to 6/30/1968 , that (I) (we) last saw the deceased alive on 6/30 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.			
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 7/2/68	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.		23D. ADDRESS 4900 Belair Road Balto., Md. 21206	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-68	
24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		24D. LOCATION (City, town, or county) (State) BALTO., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR J. Walter Conklin		ADDRESS 5444 BELAIR RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">M-320 68-6861</h2> <h3 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h3> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. 68-6861	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) LESLIE MATTHEWS		2. DATE AND HOUR OF DEATH 7/2/68 8 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF Md. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY _____ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2322 Sidney Ave.	
5. SEX m	6. RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/94
9. AGE (In years lost birthday) 74		If Under 1 Yr. Months: _____ Days: _____	If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Bon Secours Hosp	
11. BIRTHPLACE (State or foreign country) GA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 175-10-9942A	
17. INFORMANT Glora Affhauser		ADDRESS (21230) 2322 Sidney Ave	
18. 379.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory arrest (B) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19. 327.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Coronary atherosclerosis I CHF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from June 12 19 68 to July 2 19 68 , that (1) (we) last saw the deceased alive on July 1 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Paul R. Spink M.D.		23B. DATE SIGNED 7-2-68	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS University Hosp. Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/6/1968	24C. NAME OF CEMETERY or CREMATORY Greenwood	24D. LOCATION (City, town, or county) (State) Dorsey, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	25B. NAME OF REGISTRAR Robert E. Feltman	25C. FUNERAL DIRECTOR John J. Conner & Son, Inc., 901 Hallam St. Balt. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY DEPARTMENT				REG. NO. 68-6862	
5-160				68-6862	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) R. Virginia Shaffer			2. DATE AND HOUR OF DEATH JUNE 29, 1968 4:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSP			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 33rd + CALVERT STS			B. COUNTY CUMMINGS		
BALTIMORE, MARYLAND 21218			C. CITY OR TOWN HAMPSTEAD		
15. SEX FEMALE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
6. RACE CAUCASIAN			E. STREET AND NUMBER UPPER BECKLEYSVILLE ROAD		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH 4-24-20		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) 48		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CLIFTON HALE			14. MOTHER'S MAIDEN NAME PAULINE MARTIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-03-9116		
17. INFORMANT MR ROY E SHAFFER			ADDRESS UPPER BECKLEYSVILLE ROAD HAMPSTEAD, MD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 205.0 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE GRANULOCYTIC LEUKEMIA		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 204.3 II			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 204.3 II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6-17-68 1968 to JUNE 29 1968, that (I) (we) last saw the deceased alive on JUNE 29 1968 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Spencer-Strong MD			23B. DATE SIGNED June 29, 1968		
23C. PHYSICIAN'S NAME (Type) WILLIAM H. SPENCER-STRONG MD			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE July 3, 1968		
24C. NAME OF CEMETERY or CREMATORY Forrest Cemetery			24D. LOCATION (City, town, or county) (State) Upperco Balto. Co. Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			25B. NAME OF REGISTRAR Robert E. Talbot		
25C. FUNERAL DIRECTOR Tipton - Eline Funeral Home			ADDRESS Hampstead, Md.		

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Acute Granulocytic Leukemia

1994年 (12月)

27147204

CLIFTON HALL

WILLIAM H. SPENCER, JR. MD
WILLIAM H. SPENCER, JR. MD

Maryland - James H. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-360 68-6863		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6863
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lorraine ALLAN STARR		2. DATE AND HOUR OF DEATH June 30, 1968 10:15 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M		6. RACE W		E. STREET AND NUMBER 6413 FAIR OAKS Avenue
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-30-14		9. AGE (In years last birthday) 54 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY Beth. STEEL		11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND 12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME ALEXANDER STARR		14. MOTHER'S MAIDEN NAME ANNIE OWEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Adelina Suresch Starr, wife, above ADDRESS
18. 430,91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 330X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 29, 1968 to June 30, 1968, that (I) (we) last saw the deceased alive on June 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Miguel Sanchez-Palacios		23B. DATE SIGNED June 30, 1968		23C. PHYSICIAN'S NAME (Type) MIGUEL SANCHEZ-PALACIOS
23D. ADDRESS UNION MEMORIAL HOSPITAL		23E. FURNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		23F. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery
24D. LOCATION Baltimore, Md.		24E. CITY, TOWN, or COUNTY		24F. STATE
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FURNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6864	
<div style="display: flex; justify-content: space-between;"> 5-326 68-6864 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mrs. Helen Steiger		6-30-68 7:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
			A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
Hood Convalescent Home Inc. 70			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3608 Fredrick Old Rd.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F.	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 9, 1896	71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Cashier		Restaurant		New York	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Louis Bouquet			Mary E. Horan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		718-25-2835		Louis P. Steiger, 3608 Old Frederick Rd. Baltimore, Maryland 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
412.4 I			Cerebral Hemorrhage 48 hours		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			A.S.C.V.D. years		
422.1 II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 1947 to June 1968, that (I) (we) last saw the deceased alive on June 29 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		July 3, 1968		Loudon National Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 5 1968		Robert E. Taylor		G. Truman Schwab, 3512 Frederick Ave, Baltimore Maryland, 21229	

3488 Fredrick Birk

20-4-1945

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6865	
S-526		68-6865	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
YETTA SINGER		7/1/68 1 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2900 OAKTON COURT	
5. SEX FEMALE 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		8. DATE OF BIRTH 78 9. AGE (In years last birthday) 78	
10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME WILLIAM WOLFE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-36-0692D	
17. INFORMANT MRS. STELLA ZIMAN, 2900 OAKTON COURT #21209		ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CONGESTIVE HEART FAILURE 5 years	
ANTECEDENT CAUSES		ASCVD	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ANEMIA. URINARY INFECTION 6 weeks	
422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Possible pneumonia.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30/68 19 68 to 7/1 19 68 that (I) (we) last saw the deceased alive on 7/1 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Juan L. Roque		23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) JUAN L. ROQUE		23D. ADDRESS SINAI HOSPITAL OF BALTO	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-68	
24C. NAME OF CEMETERY or CREMATORY ANSHE EMUNAH (AITZ CHAIM)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Dr. E. E. Feltner	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-431		68-6866		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6866	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) DANIEL HARRY GOLDBERG				JULY 2, 1968 7:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELVEDERE NURSING HOME 90				A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 15-13	
				E. STREET AND NUMBER 2605 ROSEWOOD AVENUE #21215			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MADERA WINE CO.		10B. KIND OF BUSINESS OR INDUSTRY FOREMAN		11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-18-9854		17. INFORMANT MRS. GOLDIE GOLDBERG, 2605 ROSEWOOD AVENUE		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 I Carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 163X II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15, 1968 to July 2, 1968 , that (I) (we) last saw the deceased alive on June 15, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Marvin Goldstein				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/2/68	
23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN				23D. ADDRESS 6001 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-3-68		24C. NAME of CEMETERY or CREMATORY HEBREW YOUNG MEN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.			

THE UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

MADE

IN THE CITY OF NEW YORK

FOR THE

STATE OF NEW YORK

IN SENATE

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

1900

PRINTED BY THE COMMISSIONER OF THE LAND OFFICE

NEW YORK, 1900

THE LAND OFFICE, NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-150 68-6867				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6867	
1. NAME OF DECEASED (Type or Print) <i>Samuel LEVINE</i>				2. DATE AND HOUR OF DEATH <i>6-30-68 12:30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>LEVINDALE HEBREW HOME AND INFIRMARY</i> <i>91</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>5826 GREENSPRING AVENUE #21209</i>			
5. SEX <i>MALE</i>	6. RACE <i>CAU</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August-1888</i>		9. AGE (In years lost birthday) <i>79</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DRY GOODS</i>		11. BIRTHPLACE (State or foreign country) <i>POLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>MAYER LEVINE</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>200-14-7408</i>		17. INFORMANT <i>MRS. IRVIN HERSKOVITZ</i>		ADDRESS <i>5826 GREENSPRING AVENUE #21209</i>	
18. <i>1888 XI</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CARCINOMA BLADDER</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>1 YR</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
18. <i>1810 II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>6 No</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>No</i>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>No</i>			
22. I certify that (H) (this hospital) attended the deceased from <i>5-20</i> 19 <i>60</i> to <i>6-30</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-29</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Parker, M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6-30-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>JEFF PARKER, M.D.</i>				23D. ADDRESS <i>LEVINDALE HEBREW HOME AND INFIRMARY</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-2-68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE HEBREW</i>		24D. LOCATION (City, town, or county) (State) <i>REISTERSTOWN, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS.</i>		ADDRESS <i>6010 REISTERSTOWN ROAD</i>	

19 80

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68-6868	REG. NO.
K-452 68-6868 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>BEATRICE KALLINS</i>		2. DATE AND HOUR OF DEATH <i>6/30/68</i> <i>7:00 A</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>4 Sinai Hosp of Balto.</i> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1</i> 5. CITY OR TOWN <i>BALTO.</i> 6. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7. STREET AND NUMBER <i>6300 SHELICK DR</i>		
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/07</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO., MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			13. FATHER'S NAME <i>ABRAHAM HOFFBERGER</i>		
14. MOTHER'S MAIDEN NAME <i>LENA SILVERMAN</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT <i>MR. SIGMUND R. KALLINS</i> <i>6300 SHELICK DRIVE #21209</i>		
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>METASTATIC ADENOCARCINOMA, PRIMARY?</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 YR.</i>		
199.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/13</i> <i>19 68</i> to <i>6/30</i> <i>19 68</i> that (I) (we) last saw the deceased alive on <i>6/30</i> <i>19 68</i> and that in (my) (our) opinion death occurred on the date <i>6/30</i> <i>19 68</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward R. Cohen MD</i> 23C. PHYSICIAN'S NAME (Type) <i>EDWARD R. COHEN</i> <i>Edward R. Cohen MD</i>				23B. DATE SIGNED <i>6/30/68</i> 23D. ADDRESS <i>Sinai</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-2-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>HEBREW FRIENDSHIP</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i> 25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>			
25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS.</i>		ADDRESS <i>6010 REISTERSTOWN ROAD</i>			

100-1000

DATE

AT

TIME

BY

FOR

TO

FROM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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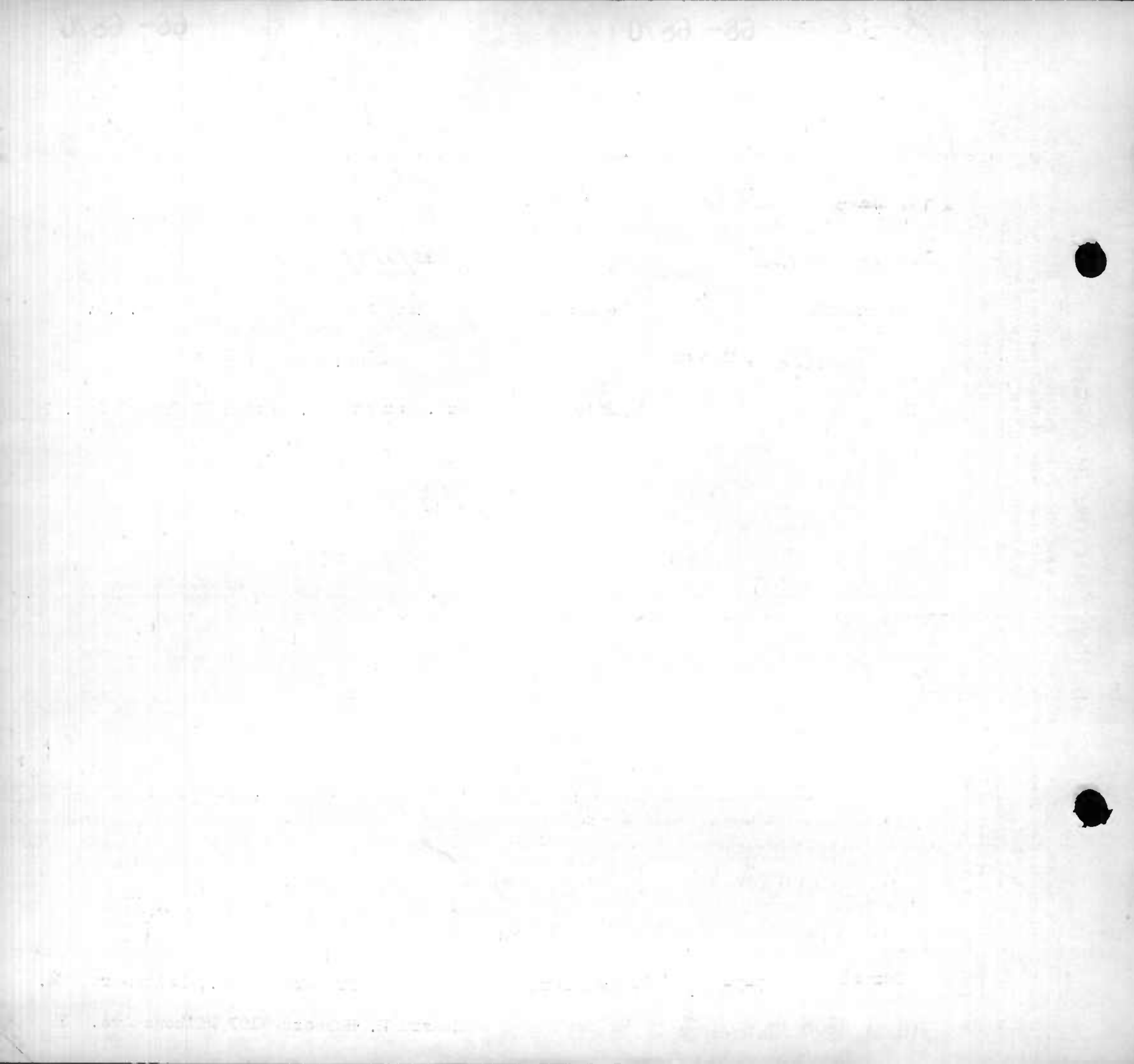
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6870
B-506 68-6870		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Bowen Mrs. Annie E.		2. DATE AND HOUR OF DEATH 6-30-68 11 30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland, Balt. Co. B. COUNTY 53-00 C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 11 Rognel Ave. zone 21229		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1887	9. AGE (In years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Homemaking		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mules, Thomas		
14. MOTHER'S MAIDEN NAME Burns, Emma		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs. Margaret M. Watson 13 Rognel Ave. 28		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 I Acute postero-lateral myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: diabetes mellitus (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260 X II				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from 6-24 19 68 to 6-30 19 68 , that (X) (we) last saw the deceased alive on 6-30 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE M. Sarkarati M.D.				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Mehdi Sarkarati M.D.				23D. ADDRESS Bon Secours Hosp.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-3-68	24C. NAME OF CEMETERY or CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Frederick Ave., Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 29		



1 **7-425 68-6871** BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH **68-6871** REG. NO. **63-00**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH J. FLEISCHMANN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 28, 1968 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 28, 1968 7:35 P.M.	
6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard	
9. DATE OF BIRTH December 5, 1911 10. AGE (In years last birthday) 56 11. BIRTHPLACE (State or foreign country) Maryland		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 7 Rustic Lane	
13. FATHER'S NAME John Fleischmann		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Coordinator	
15. MOTHER'S MAIDEN NAME Anna Reis		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-03-8281		18. INFORMANT ADDRESS Mrs. Alice V. Fleischmann, 7 Rustic Lane, 2122	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-29-68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1968	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner	
25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Avenue			

UNIT 1

UNIT 2

UNIT 3

UNIT 4

UNIT 5

UNIT 6

UNIT 7

UNIT 8

UNIT 9

UNIT 10

UNIT 11

UNIT 12

UNIT 13

UNIT 14

UNIT 15

UNIT 16

UNIT 17

UNIT 18

UNIT 19

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6872	
B-432 68-6872		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Arthur D. Bloodsworth		2. DATE AND HOUR OF DEATH July 2, 1968			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5551 Gayland Road 21227			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-1914	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Acme Market		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Bloodsworth			
14. MOTHER'S MAIDEN NAME Myrtle Daniels		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216-01-7875		17. INFORMANT ADDRESS Flossie D. Bloodsworth - 5551 Gayland Rd. 27			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Coronary Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to June 1968 , that (I) (we) lost saw the deceased alive on June 1, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John G. Orth, M.D.				23B. DATE SIGNED 7/3/68	
23C. PHYSICIAN'S NAME (Type) Dr. John G. Orth				23D. ADDRESS 8104 Analee Ave., Rosedale, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-68		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION Howard County Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard 4107 Wilkens Ave. 29			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6873	
J-520 68-6873		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JONES HELEN H.		2. DATE AND HOUR OF DEATH JULY 03, 1968 12:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS AND CATON AVENUE BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21227 B. COUNTY Baltimore 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5002 WESTLAND BLVD. APT. E			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/20/03	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINCIPLE		10B. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FREDERICK, JONES HARMON		14. MOTHER'S MAIDEN NAME DORA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218145111	17. INFORMANT ADDRESS ST AGNES HSP CATON & WILKENS AVE		
18. 7341 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest, perforated ulcer of jejunum (B) Generalized Suppurative Pythematosis (C) Generalized Suppurative Pythematosis			
MEDICAL CERTIFICATION 45-68 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 7-2-68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED jejunum resection	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JUNE 27, 1968 to JULY 3, 1968, that (X) (we) last saw the deceased alive on JULY 3, 1968 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (not) view the body after death.)					
23A. SIGNATURE Hamid		23B. DATE SIGNED 07 03 68		23C. PHYSICIAN'S NAME (Type) HAMID MEHDIZADEH, M. D.	
23D. ADDRESS ST AGNES HSP WILKENS & CATON AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-5-68	24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Ave., Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 29	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MOORE, William		7/2/68		7:30 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
The Johns Hopkins Hospital		Maryland		Baltimore	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		Negroid		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
May 18, 1919		73		Retired	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Virginia				Henry Moore	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Sallie					
17. INFORMANT		ADDRESS			
Pearl Moore		1405 N. Dallas St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		Cerebral Thrombosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Atherosclerosis			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION		20. AUTOPSY? (Yes or No)		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
332X		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 6/10 19 68 to 7/2 19 68, that (we) lost saw the deceased alive on 7/2 19 68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Joel Engelston				7/2/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Joel Engelston				The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-6-68		Mt. Calvary Em. A. A. Co	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
Baltimore		Robert E. Calver		Rayner Sanders	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	
JUL 8 1968		Robert E. Calver		Rayner Sanders	

John G. Galt

112

112

24

W. C. Galt, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6875	
R-152		68-6875		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mae Robinson		7-1-68 9:20 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 820 2052 Arlington Avenue	
5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-5-99 9. AGE (In years last birthday) 69 11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME David Robinson		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		17. INFORMANT Theodore Robinson		ADDRESS 1316 Carey St.	
18. 590.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 600.0 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Mania (B) Chronic Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 wks 5 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-28-68 19 to 7-1-68 19, that (I) (we) last saw the deceased alive on 7-1-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot, M.D.				23B. DATE SIGNED 7/2/68	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT, M.D.				23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-68		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR V.R. Bailey	
				ADDRESS 1348 N. Calhoun Street	

VS 153 7-10-68 M.H.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. _____

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) WILLIAM Wesley SPRIGGS JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 20, 1968 6:02P M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 30, 1968 6:02 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6-22-19	10. AGE (In years lost birthday) 49	11. BIRTHPLACE (State or foreign country) Md.		E. STREET AND NUMBER 1503 Laurens Street	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm. Spriggs Sr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Rachel Crosby		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 212141397	
18. INFORMANT Mary Anderson		ADDRESS 913 Whatcoat Street		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 466X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Acute purulent Laryngo-tracheo-bronchitis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20. DATE OF OPERATION 5-00X II		21. AUTOPSY? (Yes or No) yes		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty Metamorphosis of Liver	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 1, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Vernon R. Bailey			
ADDRESS 1348 Calhoun St.					

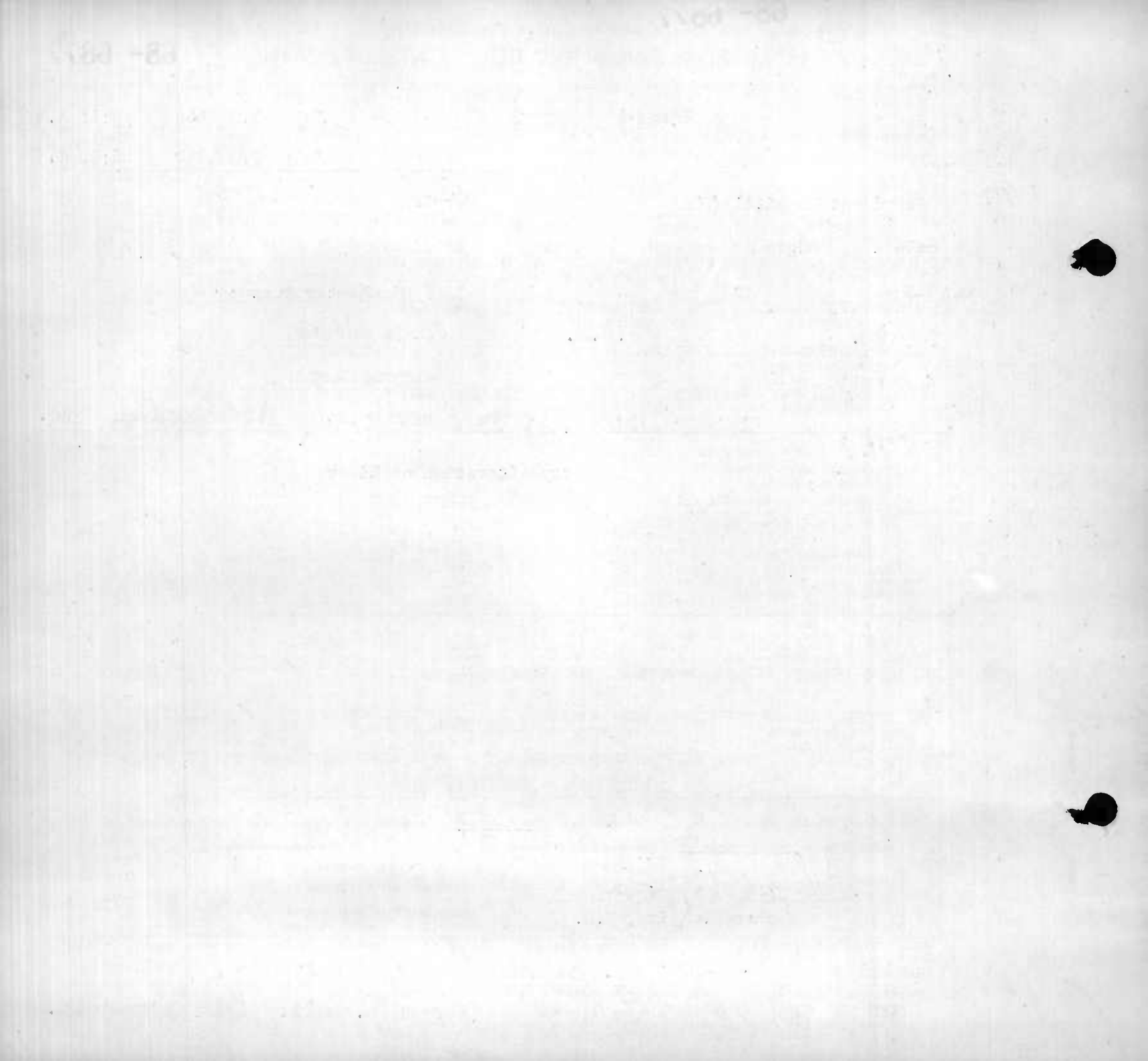
WALLBURY PRODUCTS
25% SOLID CONTENT

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68- 6877

BIRTH NO.

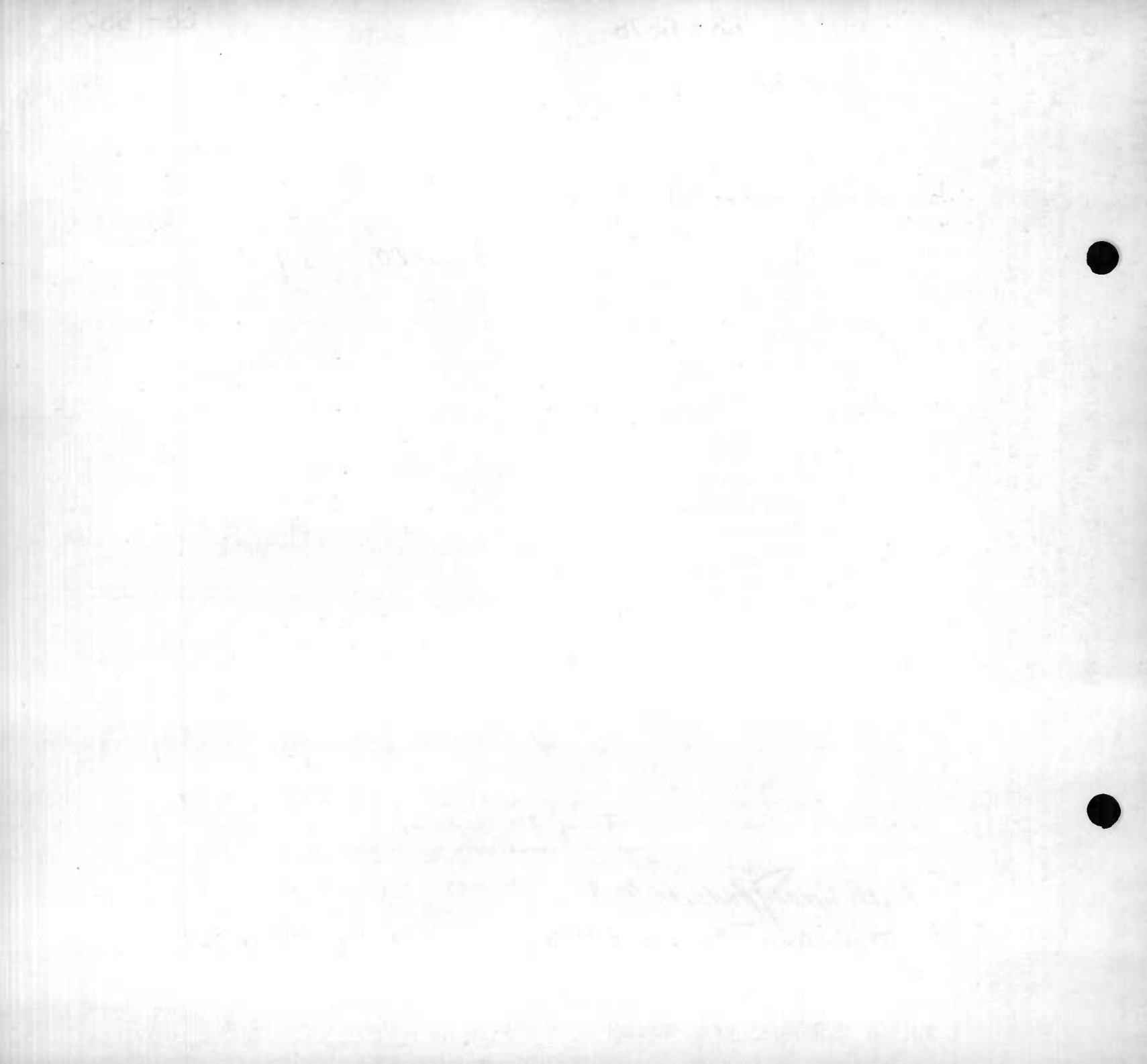
1. NAME OF DECEASED (Type or Print) JAMES Edward KEYS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> July 2, 1968 Hour 6:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1968 6:30 A.M.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3-13-26		10. AGE (In years last birthday) 42	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 219161831	
18. INFORMANT Margaret Dyson		ADDRESS 3312 Edmondson Ave.	
19. 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 7/2/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-68	
24C. NAME OF CEMETERY or CREMATORY St. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Feltner	
25C. FUNERAL DIRECTOR Vernon R. Bailey		ADDRESS 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6878	
<div style="display: flex; justify-content: space-between;"> C-460 68- 6878 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Willie A. Clary		2. DATE AND HOUR OF DEATH July 3 1968 3:40 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 715 N. Pulaski			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Clary			
14. MOTHER'S MAIDEN NAME Amelia Stokes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO. 230-05-4638		17. INFORMANT Pauline Clary			
ADDRESS 715 N. Pulaski		18. CAUSE OF DEATH I suspect Pulmonary Embolus			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 2-3 hr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 6-17-68 19 68 to 7-3 19 68 , that (H) (we) last saw the deceased alive on July 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ruth Ann Przybysz, M.D.				23B. DATE SIGNED 7-3-68	
23C. PHYSICIAN'S NAME (Type) Ruth Ann Przybysz, M.D.				23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-68		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			
25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Kernon Bailey			
ADDRESS 1348 Calhoun St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

REG. NO. 68-6879		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. D-520		68-6879	
NAME OF DECEASED (Type or Print) DEANES, PHILLIPS		2. DATE AND HOUR OF DEATH 7-3-68 4:15 a.	
PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1041 McDonough St.	
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-45
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acme Box		9. AGE (In years last birthday) 22	10. KIND OF BUSINESS OR INDUSTRY Acme Box
3. FATHER'S NAME James Newson		11. BIRTHPLACE (State or foreign country) BALTO. Md	
12. CITIZEN OF WHAT COUNTRY?		14. MOTHER'S MAIDEN NAME Margaret Gaden	
13. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO. 214-44-1415	
16. INFORMANT MARGUERITE Webster		ADDRESS 1041 McDonough St.	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Hepatic Failure (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 120 days	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Alcoholism		(A) IMMEDIATE CAUSE Laengat's Grogginess DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Alcoholism	
19. DATE OF OPERATION 7/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/9 19 68 to 7/2 19 68 , that (I) (we) last saw the deceased alive on 7/2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Joel Eggelston, M.D.		23B. DATE SIGNED 7/2/68	
23C. PHYSICIAN'S NAME (Type) JOEL EGGELESTON		23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/5/68	
24C. NAME OF CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) A. A. County, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Joseph B. Rock		ADDRESS 1304 Central Ave	

James Morrison
Gott's Shopkin
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Therapout Center
X

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6880		4	
1. NAME OF DECEASED (Type or Print)		NEVINS, BABY BOY		2. DATE AND HOUR OF DEATH JULY 3, 1968		1:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY Baltimore	
40 ST. AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 2515 HAMMONDS FERRY RD. 21227		53-00	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/02/68	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARL W. Nevins				14. MOTHER'S MAIDEN NAME BARBARA UEBEL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSPITAL		ADDRESS	
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Bilateral interventricular hemorrhage?</u> DUE TO, OR AS A CONSEQUENCE OF: (BRAIN) (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 760.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Patent ductus arteriosus, Prematurity			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JULY 2 19 68 to JULY 3 19 68, that (I) (we) last saw the deceased alive on JULY 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Maria D. Giron M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) M MARIA D GIRON M.D.				23D. ADDRESS BALTO, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1968		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		ADDRESS 21229	

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B-261

68-6881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68-6881

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE A. BECRAFT

2. DATE AND HOUR OF DEATH

JUNE 30, 1968

4:33PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL

4940 EASTERN AVE., BALTO., MD. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

509 W. MULBERRY ST., 21201

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

6-6-98

9. AGE (In years
lost birthday)

70

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Taxi Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

PERRY

Marshall Becraft

14. MOTHER'S MAIDEN NAME

Lillian Winks

ALMYRA

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

A
218-22-1007

17. RECORDS: BALTIMORE CITY HOSPITALS

ADDRESS
4940 EASTERN AVE., BALTO., MD. 21224

18. CAUSE OF DEATH

412.3 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIO-RESPIRATORY ARREST

(B) ASHD, CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF:

(C) MULTIPLE PULMONARY EMBOLI, INSUFFICIENT

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

AZOTEMIA

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/19/1968 to 6/30/1968

that (I) (we) last saw the deceased alive on 6/30/1968 and that (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Joseph Kaplan

M.D.
DEGREEAttending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/30/68

23C. PHYSICIAN'S
NAME (Type)JOSEPH KAPLAN, M.D.
JOSEPH KAPLANM.D.
DEGREE

23D. ADDRESS

BALTIMORE CITY HOSPITAL
4940 EASTERN AVE., BALTO., MD. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-4-68

24C. NAME OF CEMETERY or CREMATORY

Windsor

24D. LOCATION

(City, town, or county)

(State)

Sandy Hook md

25A. DATE REC'D BY HEALTH DEPT.

JUL 5 1968

25B. NAME OF REGISTRAR

Ruth E. Talbot

25C. FUNERAL DIRECTOR

Fleet Funeral Home

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

440.00 - 3 copies of Certificate

1881-82

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M-451		68- 6882		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 68- 6882	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Lucy Virginia (Jennie) Mullenberg			
2. DATE AND HOUR OF DEATH June 30, 1968				M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kenson Nursing Home 2922 Annapolis Avenue				A. STATE Maryland B. COUNTY Baltimore Co 53-00			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Hydes				D. STREET ADDRESS (If rural, give location) Long Green Pike			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH June 21, 1870	9. AGE (In years last birthday) 98	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Meyers				14. MOTHER'S MAIDEN NAME Fianna Mumma			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records		ADDRESS	
18. 412.4 I CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio-Vascular Disease				Several years			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 422.1 II							
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ✓		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 2, 1958 to June 30, 1968 , that (I) (we) last saw the deceased alive on June 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>Yes</u>) (<u>did</u>) (<u>did not</u>) view the body after death.							
23A. SIGNATURE Frank N. Ogden				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 2, 68	
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN				23D. ADDRESS 2701 N. Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1968		24C. NAME of CEMETERY or CREMATORY Wilson Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Long Green, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR John Burns		25C. FUNERAL DIRECTOR Sons, Towson, Maryland		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6883	
W-160		68-6883	
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
WEAVER Mr CARL A.		7-1-1968 10-15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
35 CHURCH HOME AND HOSPITAL		MARYLAND	
		C. CITY OR TOWN D. INSIDE CITY LIMITS	
		BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER	
		2625 HUDSON ST	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 11, 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
MAINTENANCE MAN (PET.)			83
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WEST VIRGINIA		AMERICA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOHN WEAVER		DELLA RICHARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No		236-01-5589	PAULINE CARNEY 2625 HUDSON ST.
18. 430.9 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		Subarachnoid hemorrhage	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
330 X II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
0			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (this hospital) attended the deceased from 6-27 1968 to 7-1 1968.			
that (we) last saw the deceased alive on 7-1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) () view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Cesar A. Lopez MD		July 2, 1968	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
CESAR A. LOPEZ MD		CHURCH HOME AND HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
BURIAL	7/5/68	RIVER HILL CEMETERY	WOOD CO. W. VA.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS	
JUL 5 1968	Robert E. Taylor	Wm. Cook-BROOKS INC. 1217 ST. PAUL ST.	

100-1001000

100-1001000

CHURCH BAPTIST

11

JOHN W. H. H.

DELLA RICHARD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

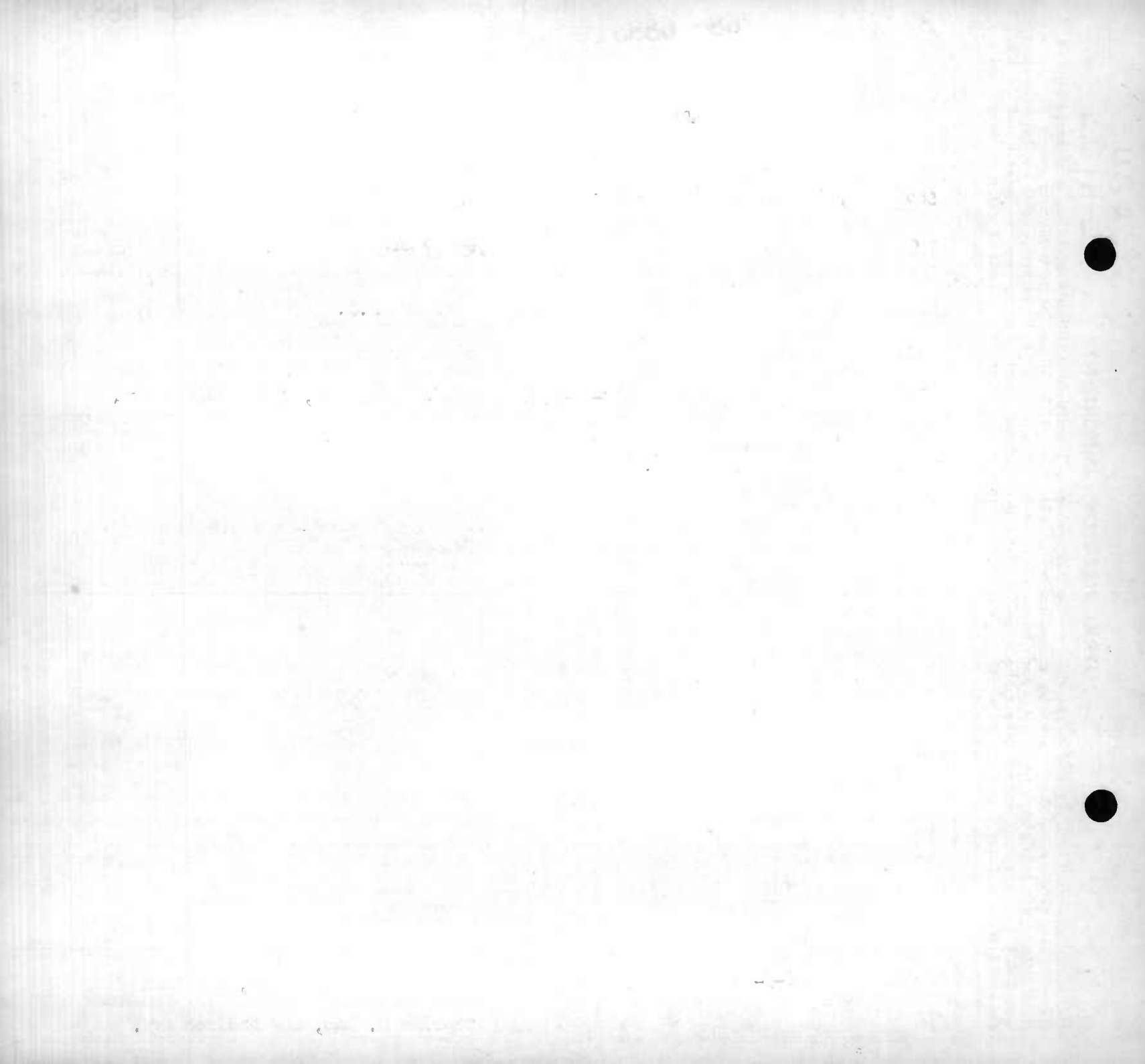
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6884	
A-500 68-6884		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GEORGE W. AMEY		2. DATE AND HOUR OF DEATH JULY 2, 1968 1:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL 36		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec 12, 1886		9. AGE (In years last birthday) 81		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED, carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Amey		14. MOTHER'S MAIDEN NAME Emma Green	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-6211-A		17. INFORMANT Mrs. Jennie E. Amey	
18. 250.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: COMA (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) 2 HRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from JULY 2, 1968 to 19 , that (I) (we) last saw the deceased alive on JULY 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Utai Ruangwit		23B. DATE SIGNED JULY 2, 1968		23C. PHYSICIAN'S NAME (Type) UTAI RUANGWIT	
23D. ADDRESS FRANKLIN SQUARE HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	
25B. NAME OF REGISTRAR Robert E. Walters		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker		25D. ADDRESS Sts.	

[Faint, mostly illegible text covering the main body of the page, possibly a memorandum or report.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-452 68-6885				BALTIMORE CITY HEALTH DEPARTMENT		68-6885	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) IRENE BLANCHARD				2. DATE AND HOUR OF DEATH JULY 3, 1968 12 ³⁰ AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, INC		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET, ADDRESS OR LOCATION)		A. STATE Md.		B. COUNTY BALTO. CITY	
C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1401 MADISON AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/10	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Talboro N.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Bulluck			14. MOTHER'S MAIDEN NAME Eliza Brown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-22-9571		17. INFORMANT Otto Blanchard, 1401 Madison Ave.		
18. 562.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Peritonitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ruptured diverticulitis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. 572.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6/8/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED SIGMOID DIVERTICULITIS		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19____ to 19____, that (I) (we) last saw the deceased alive on 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stuart H. Spielman M.D.				23B. DATE SIGNED July 3 1968		23C. PHYSICIAN'S NAME (Type) STUART H. SPIELMAN M.D.	
23D. ADDRESS SINAI HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 6-5-68		24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave.			



A-652 68- 6886 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6886

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE

ARMSTEAD

2. DATE OF DEATH

Known ☐ Estimated ☒

Month

Day

Year

Hour

July

2,

1968

1:26 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(If NOT in hospital or institution, give street address or location)

43 South Baltimore General Hospital

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

July

2,

1968

1:26 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

4-11-39

10. AGE (In years last birthday)

29

11. Under 1 Yr. If Under 24 Hrs. Months : Days : Hours : Min.

E. STREET AND NUMBER

3516 Fairview Avenue

11. BIRTHPLACE (State or foreign country)

Hobson, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MORRIS ARMSTEAD

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucille Brewer

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

57-61

17. SOCIAL SECURITY NO.

216-31-3670

18. INFORMANT

Morris Armstead

ADDRESS

3325 W. GARRISON

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Idiopathic Cardiomyopathy

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

431X II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/2/68

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-5-68

24C. NAME of CEMETERY or CREMATORY

BA Ho. NAT.

24D. LOCATION (City, town, or county) (State)

BA Ho.

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 5 1968

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

MORTON DYE

ADDRESS

1701 LAURENS

08-0800

00-0000

4-11-39

Hobson, VA

W-24

Morris, Amos

Lucille Morris

Yes 20-01

24-24-00 Morris, Amos 33375

Journal

1-2-42

Baile

Not

Boyle

MD

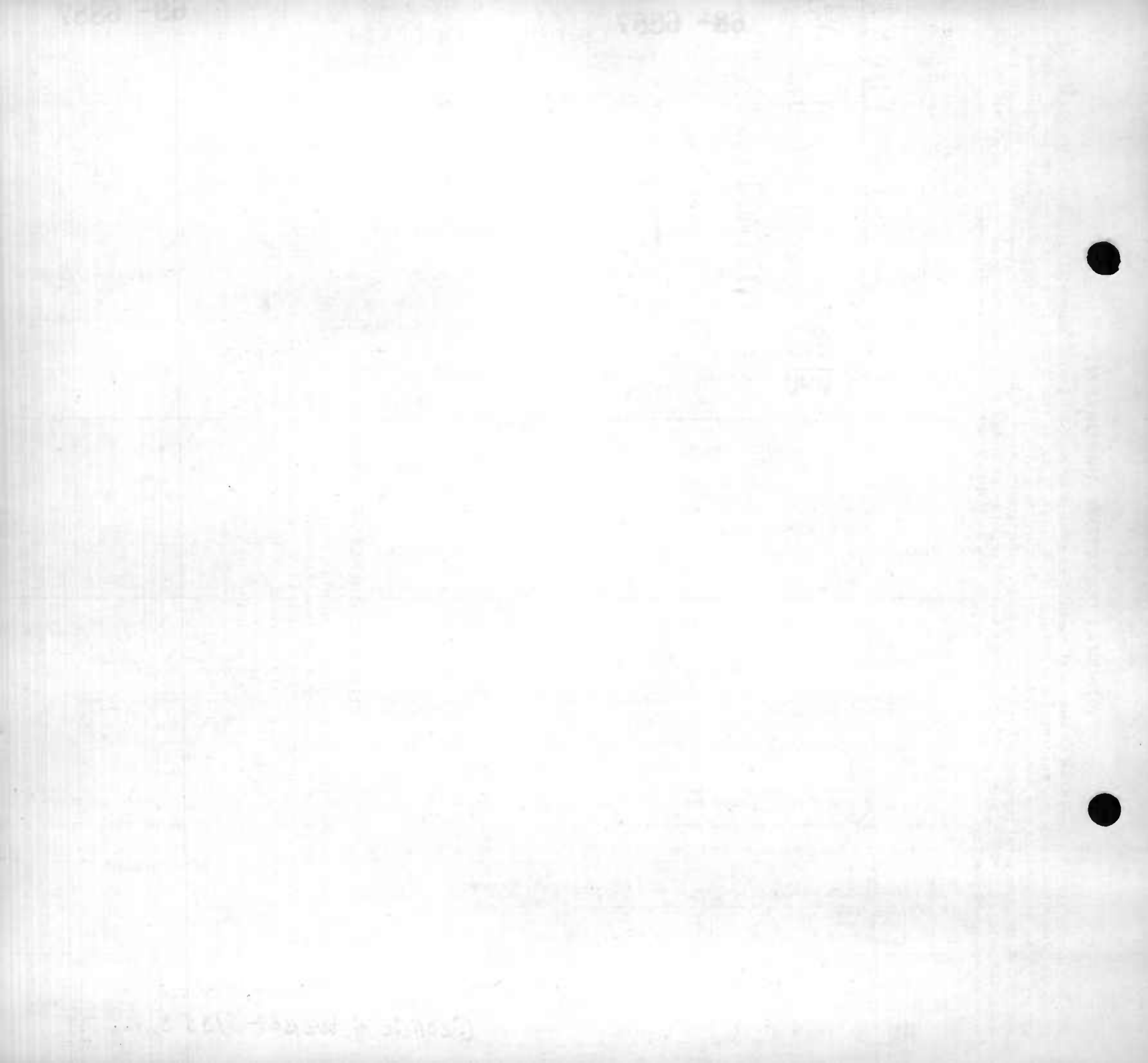
Morgan, J. H.

1901

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6887
BIRTH NO. 1. NAME OF DECEASED (Type or Print) REZNICK BESSIE REZNICK		2. DATE AND HOUR OF DEATH JULY 4 1968 8:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME'S HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 231 1/2 S. MADEIRA ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-88	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY Cannery		11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN Hudzik		
14. MOTHER'S MAIDEN NAME KATHERINE Grajek		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 		
16. SOCIAL SECURITY NO. 219-01-3624		17. INFORMANT JOSEPH REZNICK ADDRESS 231 1/2 MADEIRA ST.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE CA OF PLEURA E DUE TO, OR AS A CONSEQUENCE OF: METASTASES (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>				
163X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from JULY 3 19 68 to JULY 4 19 68 , that (I) (we) last saw the deceased alive on JULY 4 19 68 and that in (my) (our) opinion death occurred on the date JULY 4 19 68 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Corazon Z. Vergara, M.D.			23B. DATE SIGNED July 4, 1968	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.			23D. ADDRESS Church Home Hospital 107 N. Broadway Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/68		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		
25B. NAME OF REGISTRAR Robert E. Ford		25C. FUNERAL DIRECTOR GEORGE A. WEBER-705 S. Ann ST. ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-220		68-6888		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6888	
BIRTH NO.				1. NAME OF DECEASED Frank Frederick Nowakowski			
(Type or Print) Nowakowski, Frank Frederick				2. DATE AND HOUR OF DEATH 7-3-68 5 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md. U. Hosp. Baltimore, Md University Hospital				A. STATE Md.		B. COUNTY Balto.	
				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7835 Harold Rd. Balt. Co. 53-00							
5. SEX M	6. RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1905		9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACT. SUPV.		10B. KIND OF BUSINESS OR INDUSTRY SCHAFER REALTY Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Nowakowski				14. MOTHER'S MAIDEN NAME Josephine Kulacki			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-01-4395		17. INFORMANT Mrs. Jessie Nowakowski		ADDRESS #21222 7835 Harold Road	
18. 1541 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last. Staph Septicemia Adenocarcinoma of rectum				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 1 week 10 wks			
154X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 6-20-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of rectum		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 6-4-68 19 7-3 19 68 , that (I) (we) lost saw the deceased alive on 7-2- 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE Rolf Nieman, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-3-68	
23C. PHYSICIAN'S NAME (Type) Rolf Nieman M.D.				23D. ADDRESS Redwood and Greene Streets			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR George A. Weber		ADDRESS - 705 S. Ann St. #21231	

D-150

68- 6889

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6889

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> Jul 4 1968	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION		4. DATE PRONOUNCED DEAD Month Day Year July 4, 1968		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-02	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore 30		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Aug 22-1894		10. AGE (In years) lost birth day 73		E. STREET AND NUMBER 428 E. Fort Avenue	
11. BIRTHPLACE (State or foreign country) BALTO., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James F. Diviny	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Operator		14B. KIND OF BUSINESS OR INDUSTRY Real Estate		15. MOTHER'S MAIDEN NAME MARY L. MILLERBURG	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-32-9761		18. INFORMANT MRS. Helen M. JOHNSON-Fort Ave 30	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: July 4, 1968					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5 1968		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem	
24D. LOCATION (City, town, or county) (State) BALTO., Md.		24E. NAME OF REGISTRAR Robert E. Johnson		24F. FUNERAL DIRECTOR CURTIS E. EVANS	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR CURTIS E. EVANS	

88-888

88-888

WALTER BOWEN

Chas. F. F.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6890	
BIRTH NO. <u>68-6890</u>		1. NAME OF DECEASED <u>WHERRETT MARIE</u>		2. DATE AND HOUR OF DEATH <u>7-3-1968 at 4:30 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 Antietam Hospital of Maryland</u> <u>730, Annapolis Street</u>				A. STATE <u>Maryland</u> B. COUNTY <u>28-02</u>	
				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3202, Brighton Avenue</u> <u>BRIGHTWOOD</u>	
5. SEX <u>female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-89</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States of America</u>		13. FATHER'S NAME <u>Joseph Slivka</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>54-55485</u>		17. INFORMANT <u>Eleanor Pic - Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute pulmonary edema</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic heart disease</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute pulmonary edema</u> (B) <u>Arteriosclerotic heart disease</u> (C) <u>Fracture of right leg</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.0 II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>3202, Brighton Avenue, Baltimore</u>	
21D. TIME OF INJURY (APPROX.) <u>June 6-25-68 6:35 AM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>a fracture she fell down and had a fracture of the head of femur.</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6-25-68</u> 19 <u>68</u> to <u>7-3-68</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-3-68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>G. Mathprakasan</u>				23B. DATE SIGNED <u>7/3/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. MATHPRAKASAN M.D.</u>				23D. ADDRESS <u>Elkworth Armacost - 4600 Liberty Heights</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7-5-68</u>		24C. NAME of CEMETERY or CREMATORY <u>London Park Cemetery</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1968</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1968</u>		24H. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24I. FUNERAL DIRECTOR <u>Elkworth Armacost</u>	
24J. DATE REC'D BY HEALTH DEPT. <u>JUL 5 1968</u>		24K. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24L. FUNERAL DIRECTOR <u>Elkworth Armacost</u>	

18-1-80

18-1-80

No

home

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18-1-80

18-1-80

18-1-80

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6891
BIRTH NO. 68-6891		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Lotta Helen Lohmuller		2. DATE AND HOUR OF DEATH July 4, 1968 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4807 GWYNN OAK AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4807 Gwynn Oak Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-1885	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Diedrich Lohmuller		
14. MOTHER'S MAIDEN NAME DePaepe		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Claudius Freseman-4807 Gwynn Oak		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 7/2/31 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Polio - not myelitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 days 80 yrs.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from June 13 19 42 to July 4 19 68 . that (I) (we) last saw the deceased alive on July 4 1968 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (died) view the body after death.				
23A. SIGNATURE Earl L. Chambers		23B. DATE SIGNED 7/5/68		23C. PHYSICIAN'S NAME (Type) Earl L. Chambers
23D. ADDRESS 4108 Liberty Hts. Balto - Md		24A. BURIAL CREMATION REMOVAL (Specify) Burial		
24B. DATE 7-6-68		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts.

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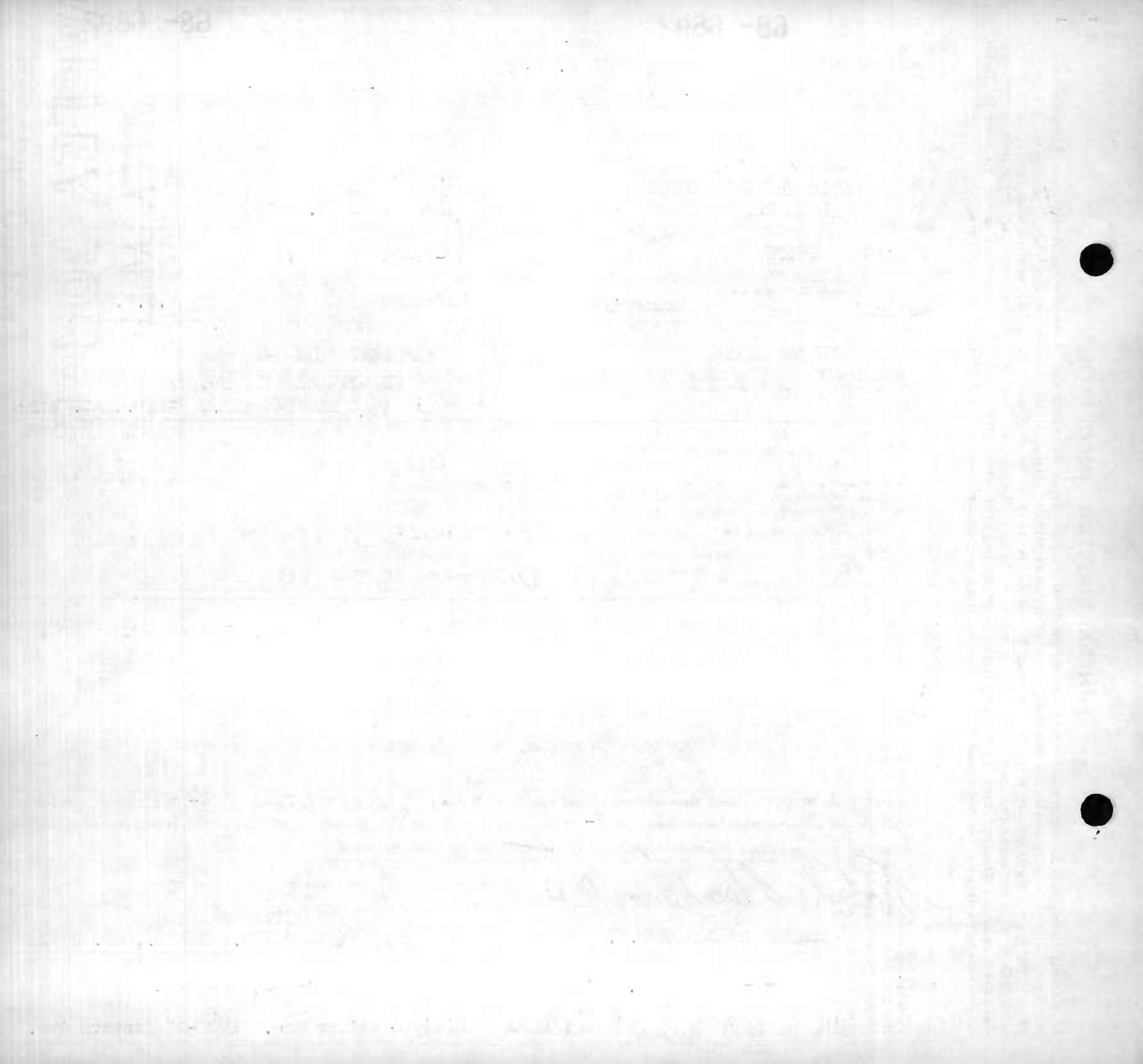
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 68- 6892

BIRTH NO.		1. NAME OF DECEASED (Type or Print) LAMOON, RUTH		2. DATE AND HOUR OF DEATH July 4 1968 9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2-03	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1824 FLEET ST. 21231					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-96	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WILLIAM DEAN				14. MOTHER'S MAIDEN NAME MARGARET WILLARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVE., BALTO., MD. 21224	
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. GENERALIZED ARTERIOSCLEROSIS 20 YEARS DIABETES MELLITUS 20 YEARS				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) GENERALIZED ARTERIOSCLEROSIS 20 YEARS DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS 20 YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II INCISION + DRAINAGE OF ABSCESS OF VULVA 3 DAYS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
19A. DATE OF OPERATION 260X II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 4-21 1967 to 7-4 1968 , that (X) (we) last saw the deceased alive on 7-4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Rosenbaum M.D.				23B. DATE SIGNED July 4, 1968	
23C. PHYSICIAN'S NAME (Type) ROBERT ROSENBAUM M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVE., BALTO., MD. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-1968		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

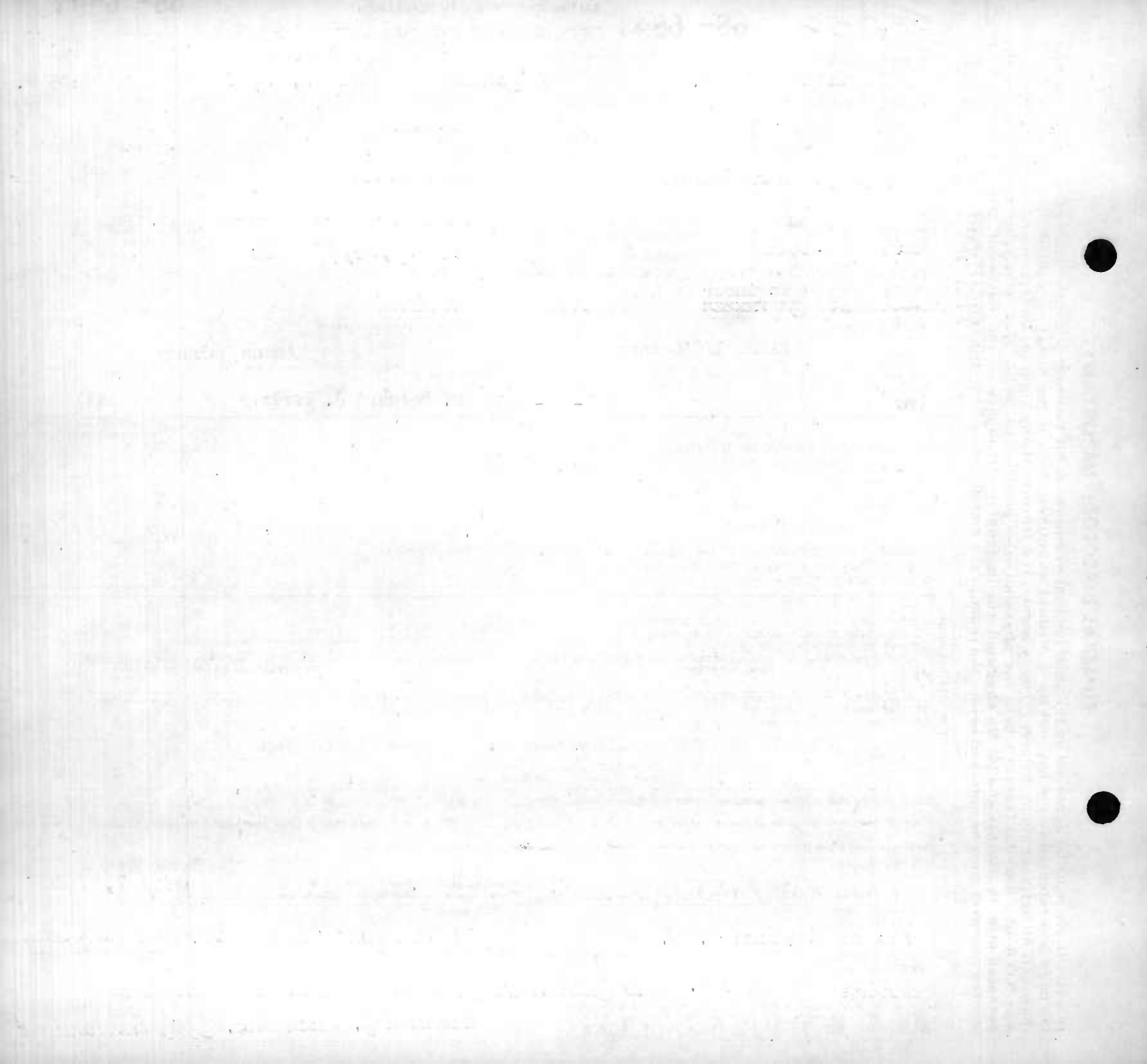
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

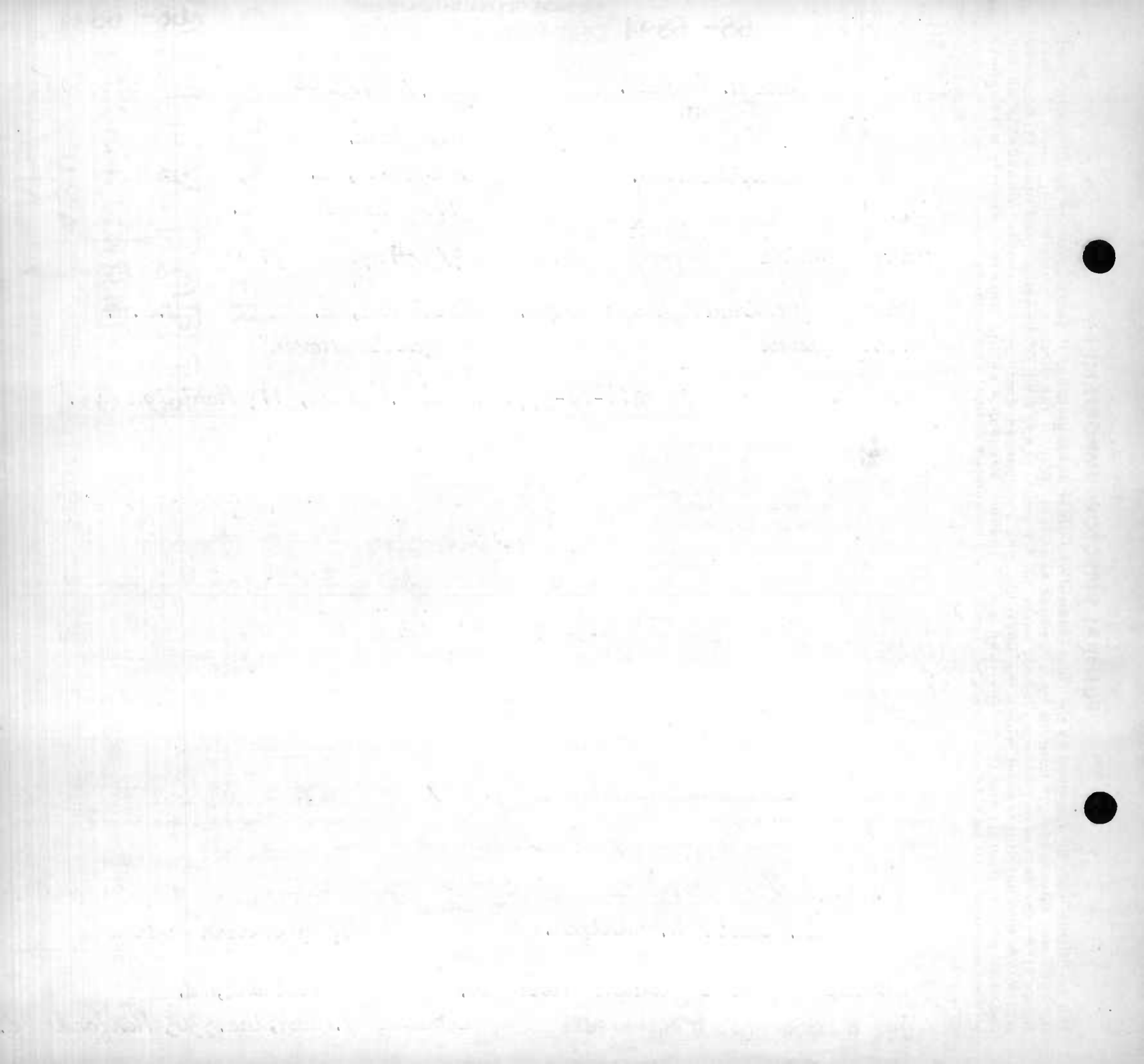
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6893	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Bernard P. O'Connor</i>		2. DATE AND HOUR OF DEATH <i>July 1, 1968</i> 4:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>5405 Elstrode Avenue</i> <i>00</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5405 Elstrode Avenue</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 15, 1879</i>	9. AGE (In years last birthday) <i>88</i> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Stationery Engineer</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i> 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Michael O'Connor</i>		14. MOTHER'S MAIDEN NAME <i>Anann Dulaney</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>262-20-8027</i>		17. INFORMANT <i>Mr. Bernard J. Barlage</i> ADDRESS <i>(Same)</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i> <i>20 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 1964</i> to <i>July 1968</i> , that (I) (we) last saw the deceased alive on <i>31 May 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas J. Brennan M.D.</i> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>July 2, 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Thomas Brennan M. D.</i>		23D. ADDRESS <i>5217 Harford Road Baltimore Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/5/68.</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. 5305 Harford Rd</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6894	
0-252 68-6894		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>John H. Ossmus.</i>		7/3/68 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hosp.</i>		A. STATE <i>Maryland.</i> B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore, Md.</i> D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i>		E. STREET AND NUMBER <i>3110 Hamilton Ave.</i>	
6. RACE <i>White</i>		8. DATE OF BIRTH <i>9/30/1896</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>71</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City (Retired Highways Dept.)</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Ossmus</i>		14. MOTHER'S MAIDEN NAME <i>Carrie Haven</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-10-3996</i>	
17. INFORMANT <i>Hazel V. Ossmus</i>		ADDRESS <i>3119 Hamilton Ave.</i>	
18. <i>410191</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Arteriosclerotic Heart Disease - acute myocardial infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Ch. Bursaculcer</i> (C) <i>gen. arteriosclerosis</i>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>4201 II</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>68</i> to <i>July 3</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Dr. Donald W. Mintzer.</i>		23B. DATE SIGNED <i>July 5 1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Donald W. Mintzer.</i>		23D. ADDRESS <i>3009 Evergreen Avenue</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/68</i>	
24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 5 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, inc.</i>		ADDRESS <i>5305 Harford Rd.</i>	



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

VERNA M. GILBERT

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00

3619 Chesterfield Avenue

3. DATE PRONOUNCED DEAD
Month Day Year Hour
July 3, 1968 1:10 P.M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

July 18, 1898.

10. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3619 Chesterfield Avenue

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John P. Grant

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Saleslady

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Virginia ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

214-12-3730

18. INFORMANT

ADDRESS

Mr. Jack H. Gilbert, 3217 Acton Rd. 21234

19.

412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1 II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 4, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/6/68.

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 5 1968

25B. NAME OF REGISTRAR

Robert E. Johnson

25C. FUNERAL DIRECTOR

Leonard J. Ryck, Inc. Balto. Md. 21214

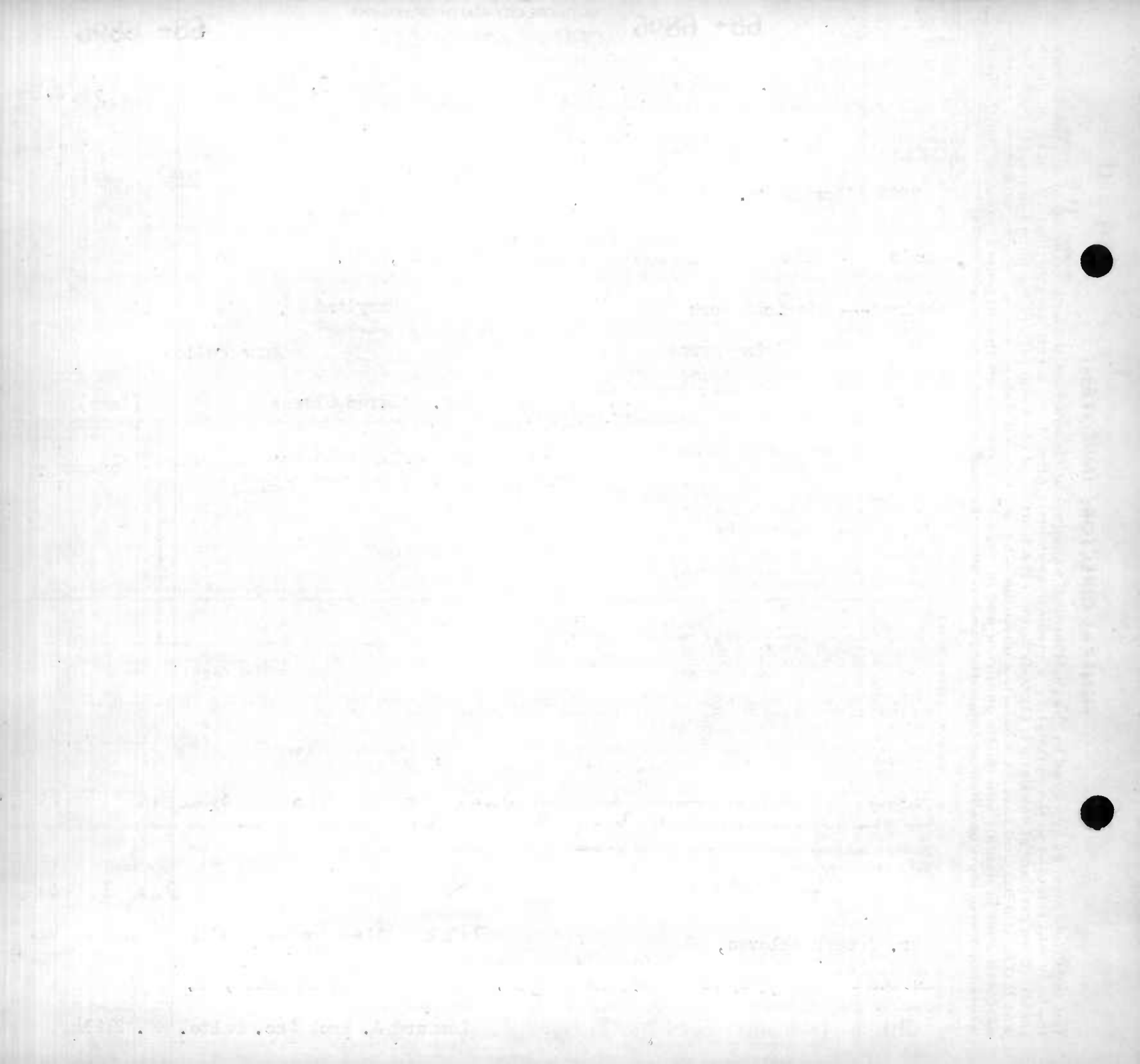
ADDRESS

Chick 2.2.2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6895	
<div style="display: flex; justify-content: space-between;"> B-650 68-6895 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Jane D. Byrne		2. DATE AND HOUR OF DEATH July 3, 1968 5 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 2908 Kildaire Dr.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2908 Kildaire Dr			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1892.	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--- Clerical Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Byrne		14. MOTHER'S MAIDEN NAME Anna Feller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215078387		17. INFORMANT Mrs. Mildred Clauss	
				ADDRESS (Same)	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardio-vascular (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs +					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 5, 1968 to June 18, 1968 , that (I) (we) last saw the deceased alive on May 21, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		DEGREE		23B. DATE SIGNED July 3, 1968	
23C. PHYSICIAN'S NAME (Type) Dr. Joseph Skloven, MD		23D. ADDRESS 7122 Harford Rd Balto Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400 68-6897				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6897	
1. NAME OF DECEASED (Type or Print) MRS. NELLIE E. KELLEY				2. DATE AND HOUR OF DEATH JULY 3, 1968 1700 HRS.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore City C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5312 PLYMOUTH ROAD			
5. SEX F	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-02-80	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PAUL ROSCHAG			14. MOTHER'S MAIDEN NAME QUAKODA JULIE ZHLE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 218-52-2924		17. INFORMANT MRS. VERA H. SELLIER (SAME) ADDRESS			
18. 0388 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FROM NEGATIVE SEPSIS				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CS			
19. 053.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 06-20-68 19 68 to 07-3- 19 68 , that (I) (we) last saw the deceased alive on 07-3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard C.W. Hall M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 3 1968	
23C. PHYSICIAN'S NAME (Type) RICHARD C.W. HALL MD. DEGREE				23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.			

From the Journal of the American Medical Association

Special Communication

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

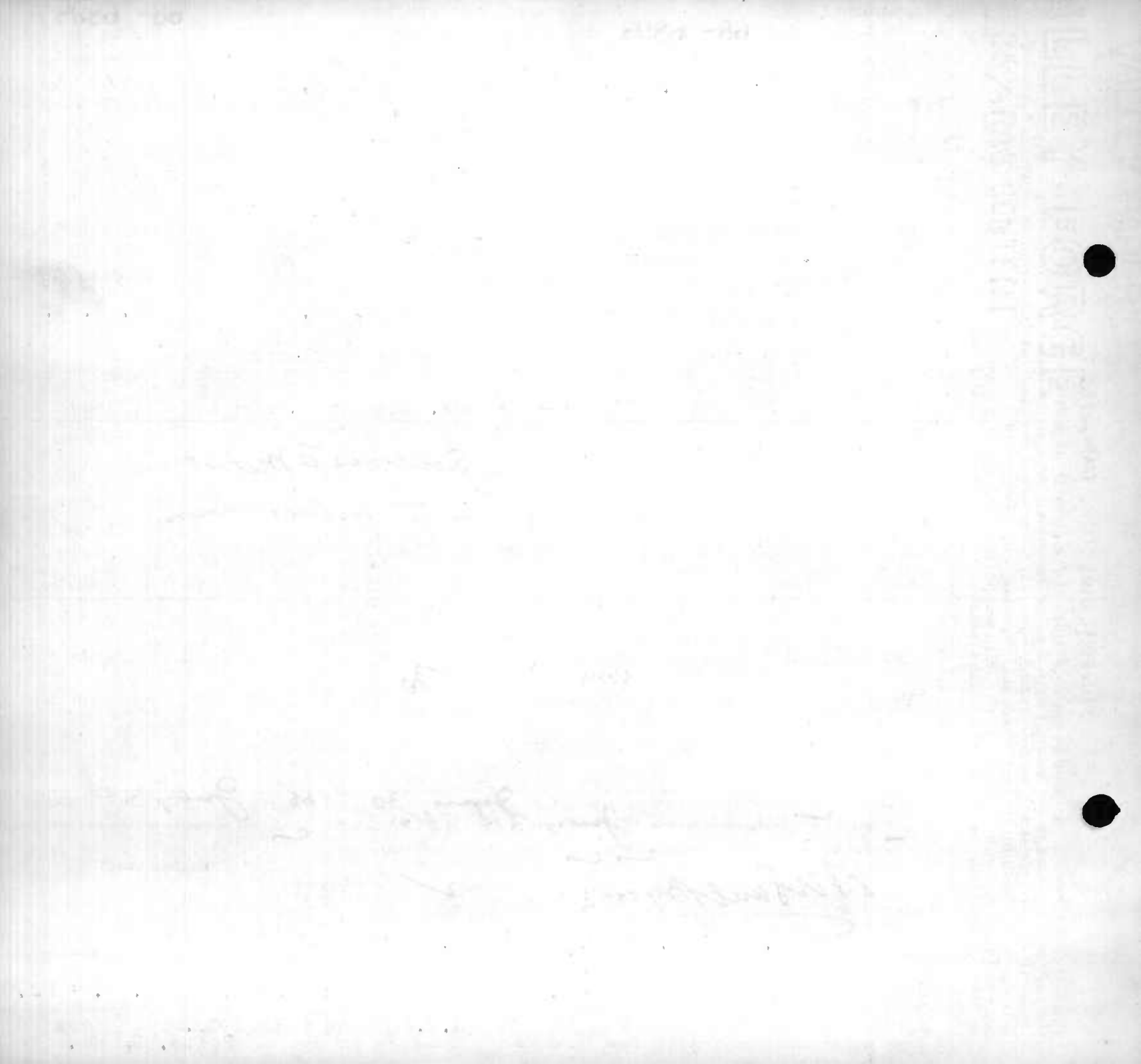
CHICAGO, ILL., U.S.A.

Vol. 10, No. 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6898	
M-264 68-6898				CERTIFICATE OF DEATH	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Ella T. McCurley			July 3, 1968		10:00 M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3939 Canterbury Road			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3939 Canterbury Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1878	9. AGE (In years last birthday) 90	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Adolph Carl Meyer			14. MOTHER'S MAIDEN NAME Florence Stellmann		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-0024	17. INFORMANT Mrs. Eleanor F. Morgan		ADDRESS (Same)
18. <u>199.0 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sarcinoma of Metastasis</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Senility. Arterio sclerosis.</i>		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. <u>199.2 II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 30</i> 19 <i>66</i> to <i>July 3rd</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 3rd</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Paul F. Byerly</i>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Dr. Paul F. Byerly			23D. ADDRESS 5820 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68	24C. NAME of CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd Balto. 12, Md.	



FUNERAL DIRECTOR: IMPORTANT

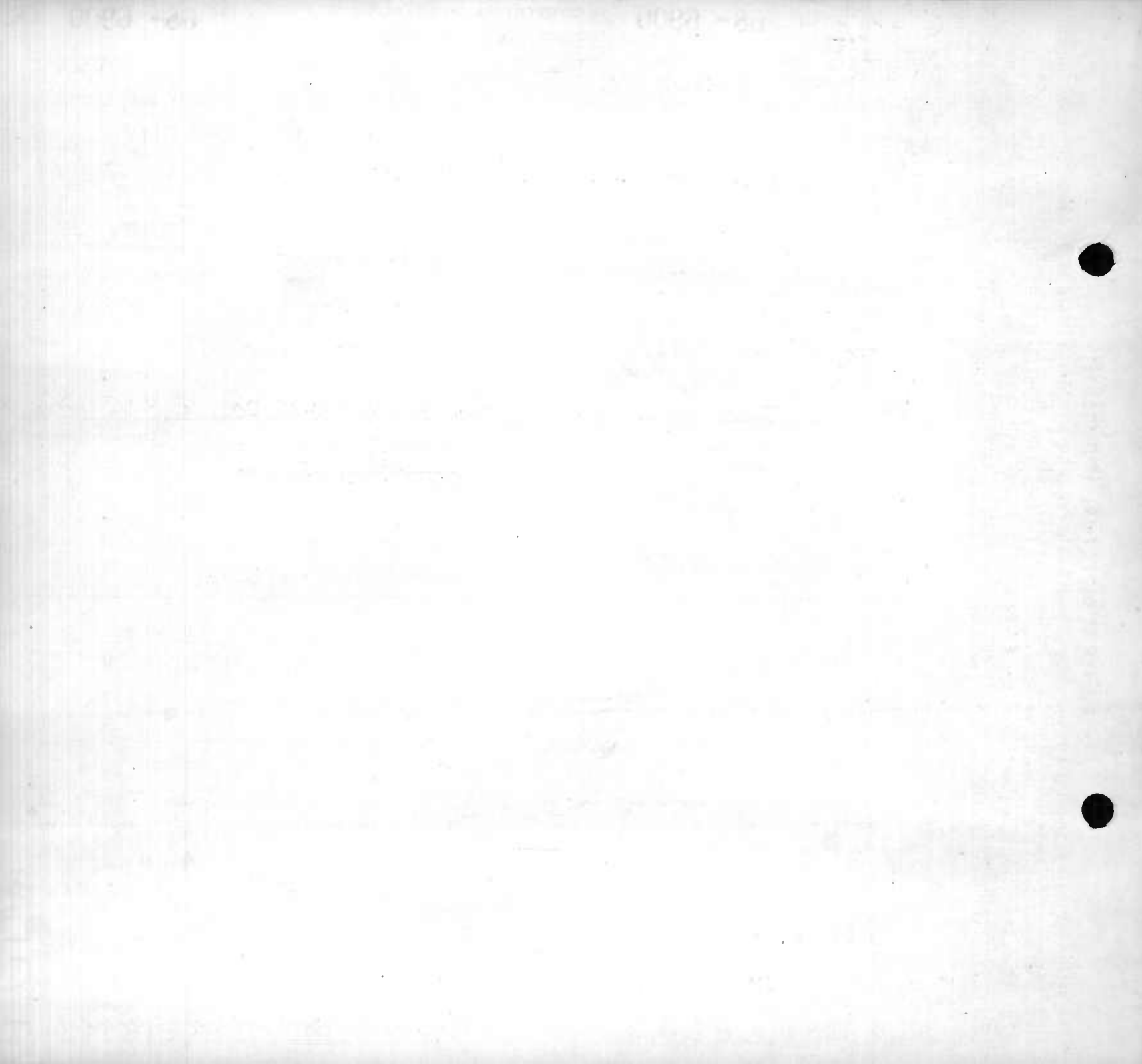
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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6899	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Anna Reddington Dolan		2. DATE AND HOUR OF DEATH 7-4-68 10:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 302 Chancery Road 00		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 7-01 E. STREET AND NUMBER 302 Chancery Road			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-1889	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland Harve DeGrace,	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Reddington			
14. MOTHER'S MAIDEN NAME Margaret Henry		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-09-3277		17. INFORMANT Mr. Peter F. Dolan			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Generalized Calcium Loss DUE TO, OR AS A CONSEQUENCE OF: Calcium of Breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 170X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 64 to July 19 68 , that (I) (we) last saw the deceased alive on July 3rd 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Francis T. Daly				23B. DATE SIGNED 7/5/68	
23C. PHYSICIAN'S NAME (Type) Dr. Francis T. Daly				23D. ADDRESS 3201 N. Charles Street Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968			
25B. NAME OF REGISTRAR P. J. F. F. F.		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.			
25D. ADDRESS 4905 York Road Balto., Md. 21212		VS 150-REV. 1/1/68			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6900	
<div style="display: flex; justify-content: space-between;"> C-623 68-6900 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PETER CORCODILOS		2. DATE AND HOUR OF DEATH JULY 5, 1968 1 35/ a. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2017 E. BALTIMORE ST.					
5. SEX MALE	6. RACE WHITE	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 1-14-93	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN CORCODILOS			14. MOTHER'S MAIDEN NAME MARY UNK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	17. INFORMANT BLANCHE CORCODILOS 2017 E BALTIMORE ST		
18. 15381 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Respiratory Failure CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure (B) Pulmonary Neoplasm DUE TO, OR AS A CONSEQUENCE OF: (C) Probably metastatic from colon. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 15381 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 3, 1968 to July 5, 1968 , that (I) (we) last saw the deceased alive on July 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David H. Katz, M.D.				23B. DATE SIGNED July 5, 1968	
23C. PHYSICIAN'S NAME (Type) DAVID H. KATZ			23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE JULY 8 1968	24C. NAME OF CEMETERY or CREMATORY ANNUNCIATION GREEK CEM	24D. LOCATION (City, town, or county) (State) WINDSOR MILL RD MD		
25A. DATE REC'D BY HEALTH DEPT. JUL 5 1968	25B. NAME OF REGISTRAR Robert E. Fisher	25C. FUNERAL DIRECTOR ADDRESS THE DIPPEL BROS INC 1800 E LOMBARD ST			



45-59-00 LB

S-530

68-6901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 68-6901

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)WILLIE BELLE SMITH
Willie Belle Smith

2. DATE AND HOUR OF DEATH

7-6-68 7-6-68

3:00PM

3:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4940 EASTERN AVE., BALTO., MD. #21224

S. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-14-95

9. AGE (In years lost birthday)

72

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ZEKE BISHOP

14. MOTHER'S MAIDEN NAME

SALLIE Williams

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL SECURITY NO.

249-56-1864

17. INFORMATION

RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. #21224

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

CVA

(B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF:

(C)

> 5 years

> 5 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

White At Work ☐ Not White At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-5 1966 to 7-6 1968, that (I) (we) last saw the deceased alive on 7-6 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Robert G. Rosenbaum, M.D.*Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

7-6-68

23C. PHYSICIAN'S NAME (Type)

ROBERT A. ROSENBAUM, M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD. #21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-12-68

24C. NAME OF CEMETERY OR CREMATORY

Greenwood Cemetery

24D. LOCATION (City, town, or county) (State)

Greenville, S.C.

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1968

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

John M. Johnson, 1700 Druid Hill Ave.

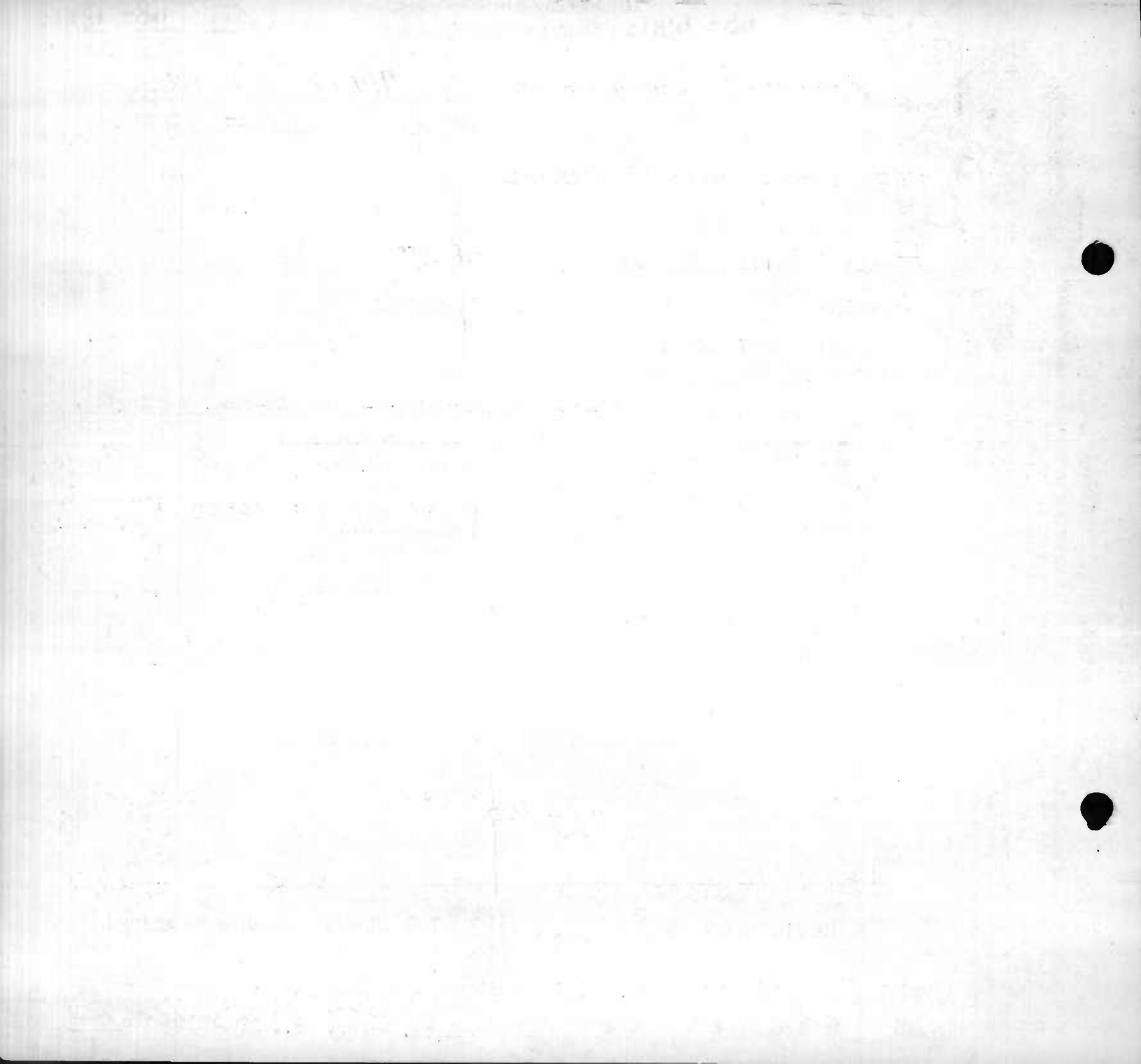
ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6902
B-633		68- 6902		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Elinor MARGARET BROADWATER		2. DATE AND HOUR OF DEATH 7/4/68 10:00 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ALLEGANY			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN CUMBERLAND		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-16	
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME HERKIE NORTHCRAFT		14. MOTHER'S MAIDEN NAME MARY McDONALD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-5033		17. INFORMANT John Kilroy-Phone 449-6064, Washington, DC	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SUBARACHNOID BLEED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 330X II		21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBARACHNOID BLEED		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
22. DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA		23. DUE TO, OR AS A CONSEQUENCE OF:			
24. DATE OF OPERATION 7/4/68		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) YES	
27. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		28. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
30. TIME OF INJURY (APPROX.)		31. INJURY OCCURRED		32. HOW DID INJURY OCCUR?	
33. I certify that (I) (this hospital) attended the deceased from 6/7/68 19 to 7/4/68 19		34. that (I) (we) last saw the deceased alive on 7/4/68 19		35. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
36. SIGNATURE Kevin Hennessey, M.D.		37. DATE SIGNED 7/4/68		38. PHYSICIAN'S NAME (Type) KEVIN HENNESSEY	
39. BURIAL CREMATION, REMOVAL (Specify) Burial		40. DATE 7/8/1968		41. NAME OF CEMETERY OR CREMATORY Greenmount	
42. LOCATION (City, town, or county) Cumberland, Maryland		43. DATE REC'D BY HEALTH DEPT. JUL 8 1968		44. NAME OF REGISTRAR John J. Hafer, Jr.	
45. ADDRESS 280 Balto Ave Cumberland Md		46. FUNERAL DIRECTOR John J. Hafer, Jr.		47. ADDRESS 280 Balto Ave Cumberland Md	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-6903

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EFFIE ROSE WERTZ		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> June 23, 1968 Hour UNK M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1511 Bolton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1968 9:05 P.M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 5, 1906		10. AGE (In years lost birthday) 61	
11. BIRTHPLACE (State or foreign country) Columbia, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
15. MOTHER'S MAIDEN NAME Marion Minson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-30-7342		18. INFORMANT Mrs. Georgia Stewart	
19. CAUSE OF DEATH Fatty Alteration of Liver		ADDRESS 2508 Indian Hill Rd. Va. Beach, Va.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 5-8-10		11	
20A. DATE OF OPERATION 8-8-10		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 7/2/68	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem.		24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

ALTH DEPARTMENT									
68-12671 68-6904 CERTIFICATE OF DEATH									
REG. NO. 68-6904									
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Baby Girl (Charlotte Landshof)</i>				2. DATE AND HOUR OF DEATH <i>7-2-68</i> <i>9:40</i> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Timonium</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <i>309 Jodyway</i>									
5. SEX <i>7</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 2, 1968</i>		9. AGE (In years last birthday) <i>6 hours</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas A. Landshof</i>				14. MOTHER'S MAIDEN NAME <i>Suzanne Hovey</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Mr. Thomas A. Landshof 309 Jodyway</i>					
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>RESPIRATORY DISTRESS SYNDROME</i> DUE TO, OR AS A CONSEQUENCE OF: <i>PREMATURITY</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>773.5 II</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Arturo R. Santos, M.D.</i> OEGREE				23B. DATE SIGNED <i>7-2-68</i>					
23C. PHYSICIAN'S NAME (Type) <i>ARTURO R. SANTOS, M.D.</i> OEGREE		23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/5/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Restland Memorial Cemetery</i>		24D. LOCATION <i>East Hanover, N.J.</i>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Towson 1050 York Rd. 21204</i>					

Mr. C. C. C.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

21



THE BODY OF LEROY COLLUMS WAS RELEASED AS NO MEDICAL EXAMINER GENERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-452		68-6906		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6906					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) COLLUMS, LEROY N.				2. DATE AND HOUR OF DEATH 7/4/68 10:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO				5. SEX MALE 6. RACE CAUC.			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS - HOPKINS HOSPITAL				C. CITY OR TOWN TOWSON				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 942 DULANOV RD.				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-27-1922			
9. AGE (In years lost birthday) 45				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				11. BIRTHPLACE (State or foreign country) BALTIMORE, MD			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME SAMUEL L.				14. MOTHER'S MAIDEN NAME DASLEY ISON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO				16. SOCIAL SECURITY NO. 212-09-3785				17. INFORMANT JOHN W. BARGER			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19A. DATE OF OPERATION 7/4/68 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 7/4/68 to 7/4/68, that (I) (we) last saw the deceased alive on 7/4/68 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 7/4/68 23C. PHYSICIAN'S NAME (Type) RICHARD N. SCOTT 23D. ADDRESS J. H. H. Best, M.D.				24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7-8-68 24C. NAME OF CEMETERY or CREMATORY Prospect Hill 24D. LOCATION (City, town, or county) (State) Towson, Baltimore, Md. 21204 25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md.							

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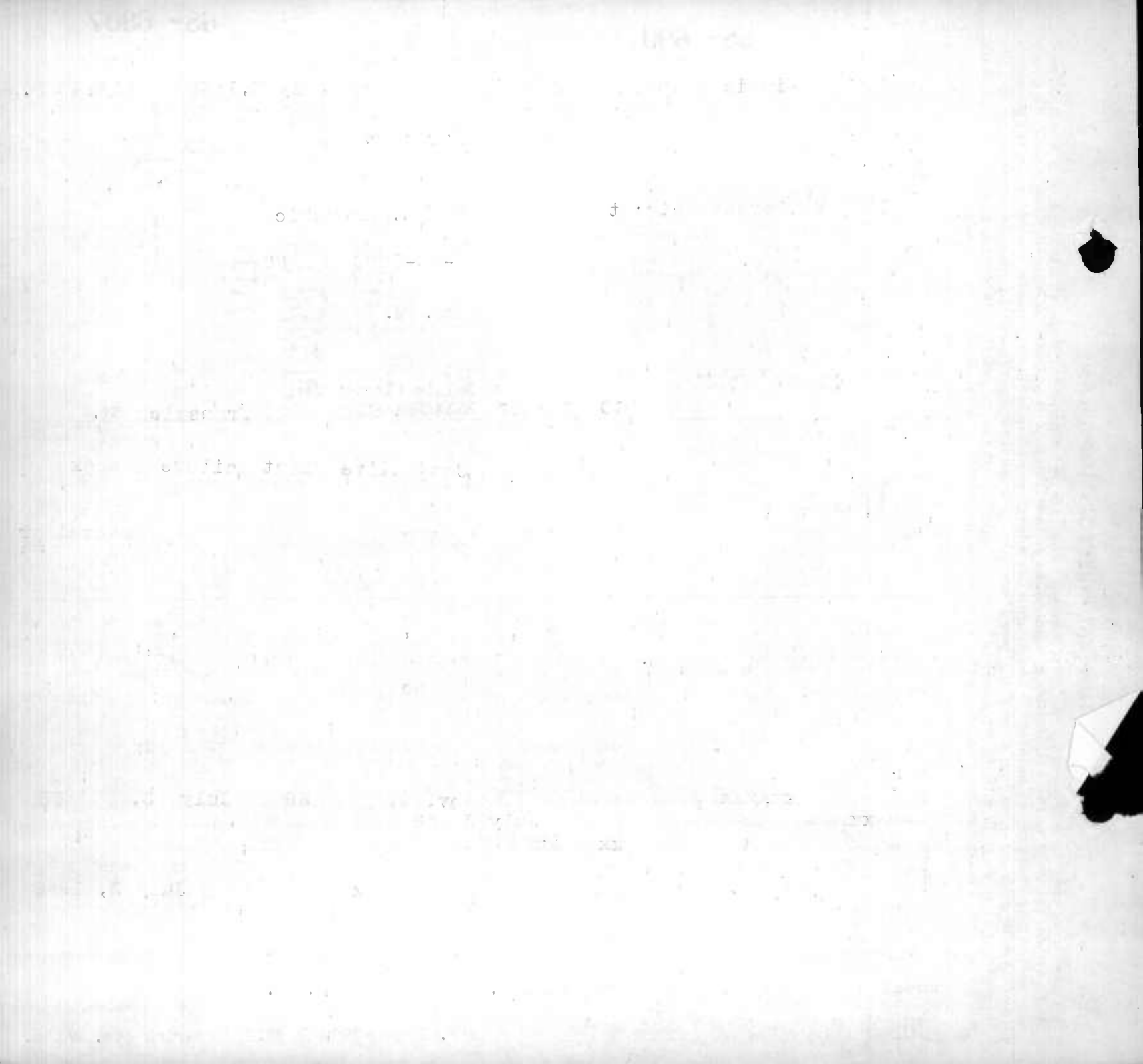
1/4
Richard N. Scott
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1/4 30 1/4 30
J.M.N. Best, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

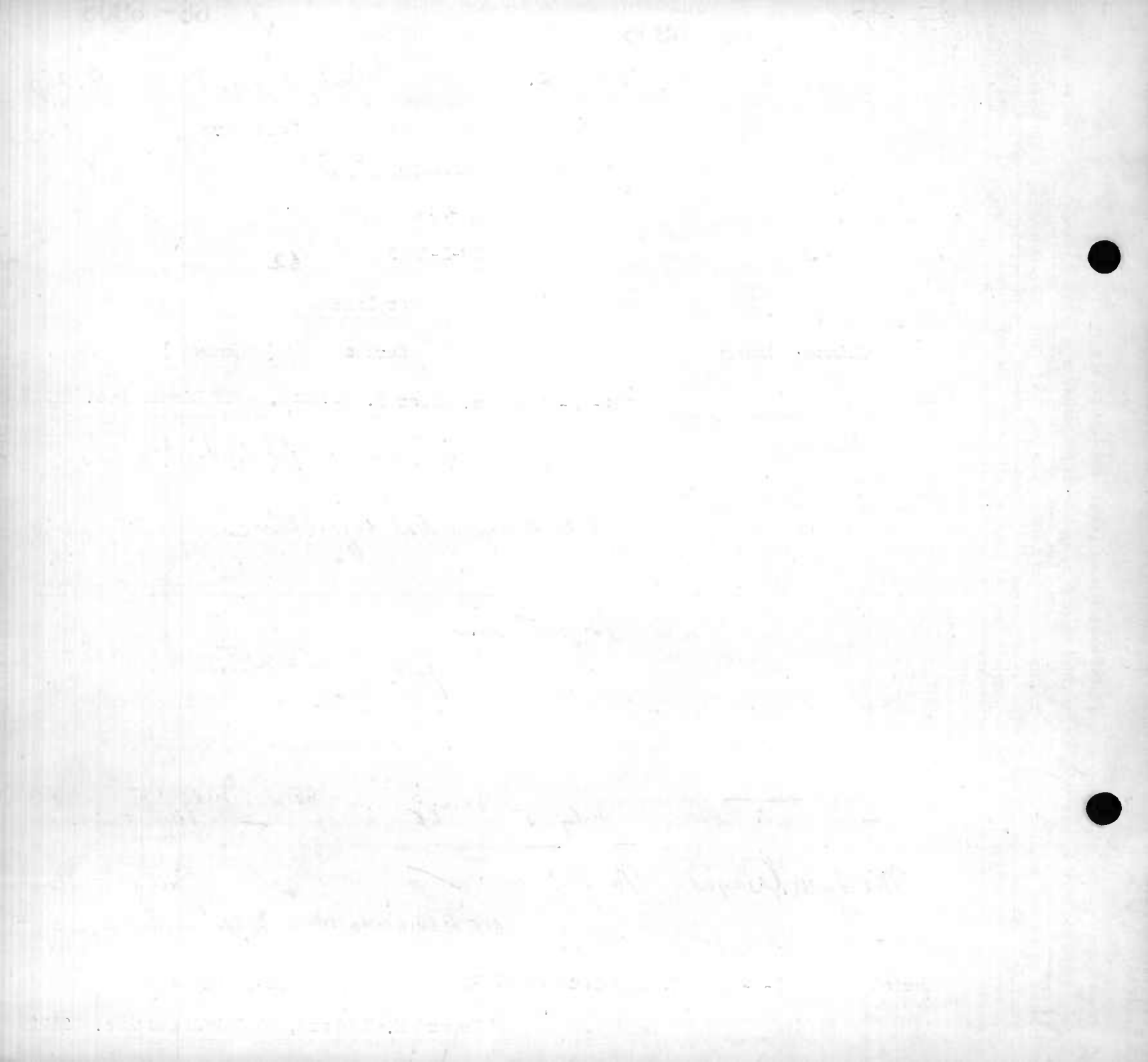
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6907	
<div style="display: flex; justify-content: space-between;"> W-560 68-6907 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Minnie Wehner			2. DATE AND HOUR OF DEATH July 3, 1968 12:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 90 </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1105 E. Fayette Street </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 8. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 520 S. Brunswick		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1890	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?			10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME ?		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 219 01 8293			17. INFORMANT Nellie Flandorffer ADDRESS 520 Brunswick St.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE Conjunctive Heart Failure 1 week DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (B) ASCVD Several yr DUE TO, OR AS A CONSEQUENCE OF: </div> <div> (C) </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 422.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) did not attended the deceased from Nov. 9, 19 66 to July 3, 19 68, that (I) last saw the deceased alive on July 3, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED July 3, 1968	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5, 1968		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) Balto. Md.		24E. STATE			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. Truman Schwab	
25D. ADDRESS 3512 Frederick Ave. Balto.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6908	
<div style="display: flex; justify-content: space-between;"> E-520 68- 6908 CERTIFICATE OF DEATH </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) EWING NELSON J.			2. DATE AND HOUR OF DEATH July 5, 1968 9:25pm.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND			A. STATE MARYLAND B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
46			E. STREET AND NUMBER 1212 MAPLE AVE.		
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-1905	9. AGE (in years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Train Operator - Balto Gas & Electric			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Clinton Ewing			14. MOTHER'S MAIDEN NAME Bertha (Unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-05-6266		
17. INFORMANT Mr. Oscar R. McGowan, 4419 Linden Ave. 21227			ADDRESS		
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) Ventricular tachycardia and fibrillation					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction					
(B) DUE TO, OR AS A CONSEQUENCE OF: 25 days					
(C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2 1968 to July 5 1968 , that (I) (we) last saw the deceased alive on July 5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Morton Krieger M.D.				23B. DATE SIGNED July 5, 1968	
23C. PHYSICIAN'S NAME (Type) MORTON KRIEGER M.D.				23D. ADDRESS 615 Hammonds Lane Baltimore, Md 21225	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-1968		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6909
4-252 68- 6909		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Hawkins, Mr James		2. DATE AND HOUR OF DEATH 7-4-1968 4:50 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home's Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 109 51 Broadway		
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-99	9. AGE (In years last birthday) 68 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A. American		13. FATHER'S NAME Michael Hawkins		
14. MOTHER'S MAIDEN NAME Mary Mc Dermott		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I 041-12-2803		
16. SOCIAL SECURITY NO. 041-12-2803		17. INFORMANT Self ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.31 CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.0 II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart disease, Congestive Heart Failure, Cardiac Arrhythmia, Emphysema, chronic cor pulmonale (C) Malnutrition		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 27 1968 to July 4 1968 , that (I) (we) last saw the deceased alive on July 4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE B. C. VENERACION		23B. DATE SIGNED JULY 4, 1968		23C. PHYSICIAN'S NAME (Type) B. C. VENERACION
23D. ADDRESS CHURCH HOME AND HOSPITAL		23E. FUNDING AGENCY		
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL	24B. DATE 7/8/68	24C. NAME OF CEMETERY or CREMATORY OAK LAWN	24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR ADDRESS W. Bruce Bradley, Headlath, Md.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 68-6910	
BIRTH NO. K-620							
1. NAME OF DECEASED (Type or Print) Kirk, Mrs. Sophie C.				2. DATE AND HOUR OF DEATH 7-4-68 7:30 PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6820 Martin Avenue 21222			
5. SEX F		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-90 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Housewife				10B. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME William Rode				14. MOTHER'S MARDEN NAME Catherine Davis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215226587		17. INFORMANT MR. BENJAMIN KIRK - AS IN #4 ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 250.9 I				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VENTRICULAR FIBRILLATION (B) ? DIGITALIS TOXICITY DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (C) DIABETES MELLITUS			
19A. DATE OF OPERATION 260X II				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from 6/12 1968 to 7/4 1968 that (I) (we) lost saw the deceased alive on 7/4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B. C. Veneration				23B. DATE SIGNED 7/8/68		23C. PHYSICIAN'S NAME (Type) B. C. Veneration	
23D. ADDRESS CHH.							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/68		24C. NAME OF CEMETERY or CREMATORY OAK LAWN		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Walter Taylor, Director, Hilditch, Inc.		ADDRESS	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

LAURA A. D. BENTLEY

1. NAME OF DECEASED
(Type or Print)

LAURA A. BENTLEY

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

Month

Day

Year

Hour

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 700 FLEET STREET

3. DATE
PRONOUNCED DEAD

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

6. SEX

F

7. RACE

W

8. MARRIED

NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1871
Oct 25 187110. AGE (In years,
lost birthday)

96 1871

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2500 N. Calvert St. 21218

11. BIRTHPLACE (State or foreign country)

CONN.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALBERT DENISON

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CHRISTIAN SCIENCE PRACTITIONER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

MARY W. BENTLEY (Maiden name)

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

220-44-5990

18. INFORMANT

R.A. SNYDER - 2204 N. CHARLES ST
BALTIMORE, MD 21218

ADDRESS

19.

412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Atherosclerotic
Cardio Vascular disease.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Werner H. Spitz M.D.
WERNER H. SPITZCHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7.7.68

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

CREMATION

7/8/1968

GREENMOUNT CRE.

BALTIMORE, MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1968

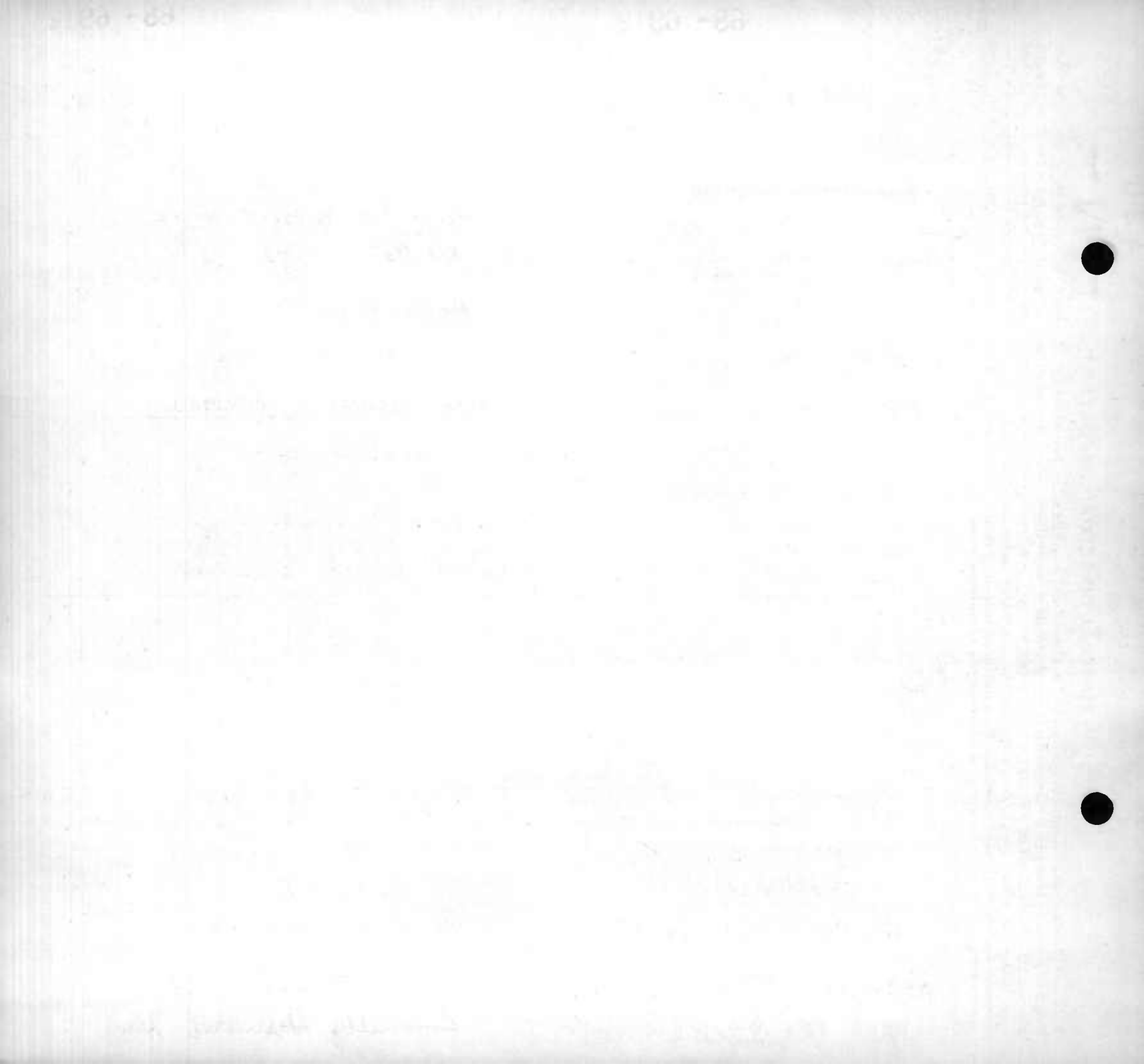
Robert E. Talley, M.D.

W. Brooks Bradley, DUNDALK, MD.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

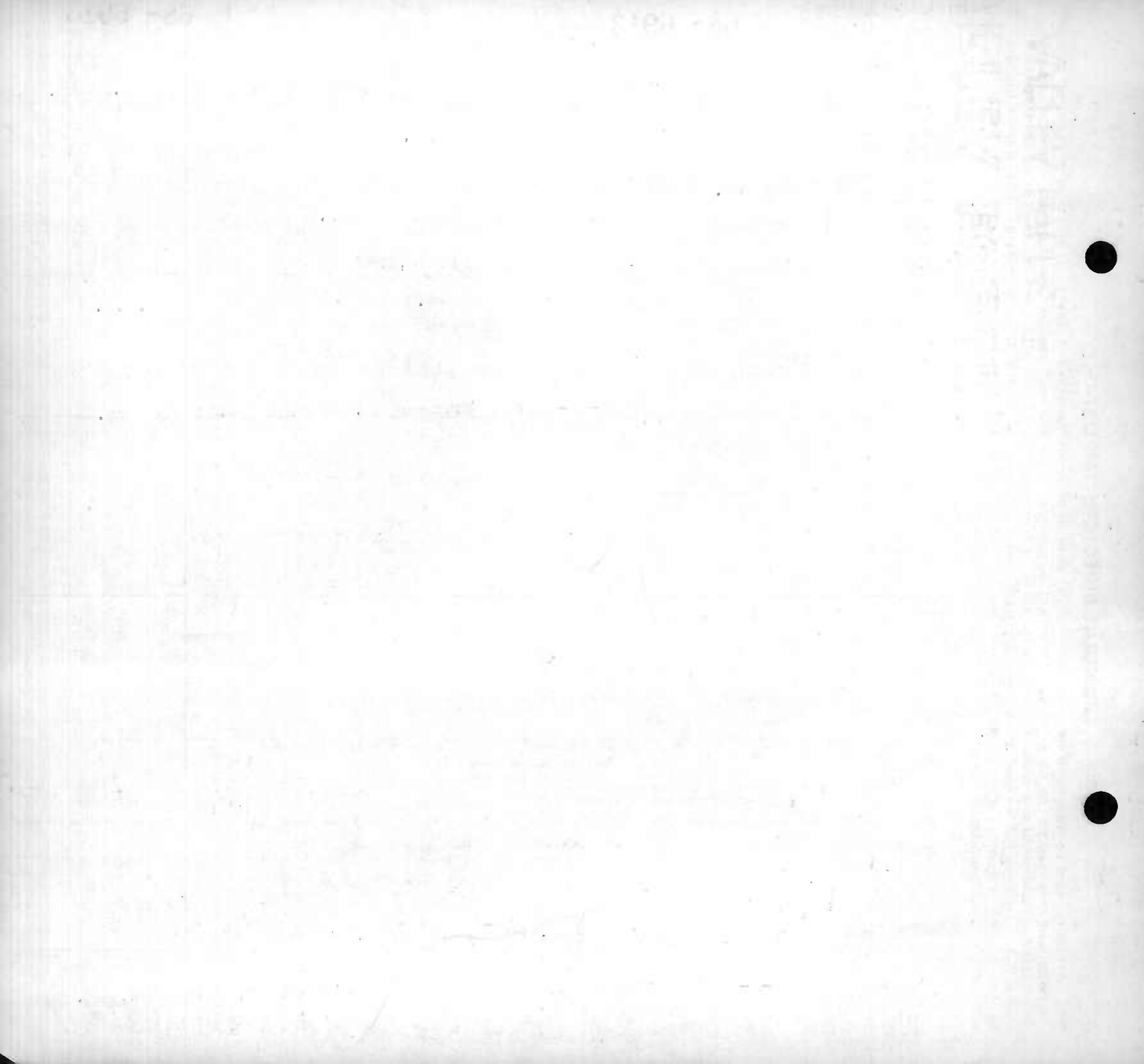
BALTIMORE CITY HEALTH DEPARTMENT C-416 68- 6912 CERTIFICATE OF DEATH				REG. NO. 68- 6912	
1. NAME OF DECEASED (Type or Print) <i>Cleaver, Elizabeth</i>			2. DATE AND HOUR OF DEATH <i>7/2/68</i> <i>12 30 A M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4 Bon Secours Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balto Co</i> C. CITY OR TOWN <i>53-00</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>8/31/95</i> 9. AGE (In years last birthday) <i>72</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Austria-Hungary</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Andrew Orda</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>BON SECOURS RECORDS</i>			ADDRESS		
18. <i>154.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Brain sep. septicaemia</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Retropneumothorax abscess</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Perforated peptic carcinoma</i> (C)		
19. DATE OF OPERATION <i>21</i>			20A. AUTOPSY? (Yes or No) <i>No</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>6-30</i> 19 <i>68</i> to <i>7/2</i> 19 <i>68</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>7/2</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>M. Sarkarati</i>			23B. DATE SIGNED <i>7/2/68</i>		
23C. PHYSICIAN'S NAME (Type) <i>Mehdi Sarkarati</i>			23D. ADDRESS <i>Bon Secours Hosp.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		24B. DATE <i>7/3/68</i>		24C. NAME OF CEMETERY or CREMATORY <i>RELOC CEM</i>	
24D. LOCATION (City, town, or county) <i>RELOC PA</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Connolly Funeral Home</i>	
25D. ADDRESS <i>300</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

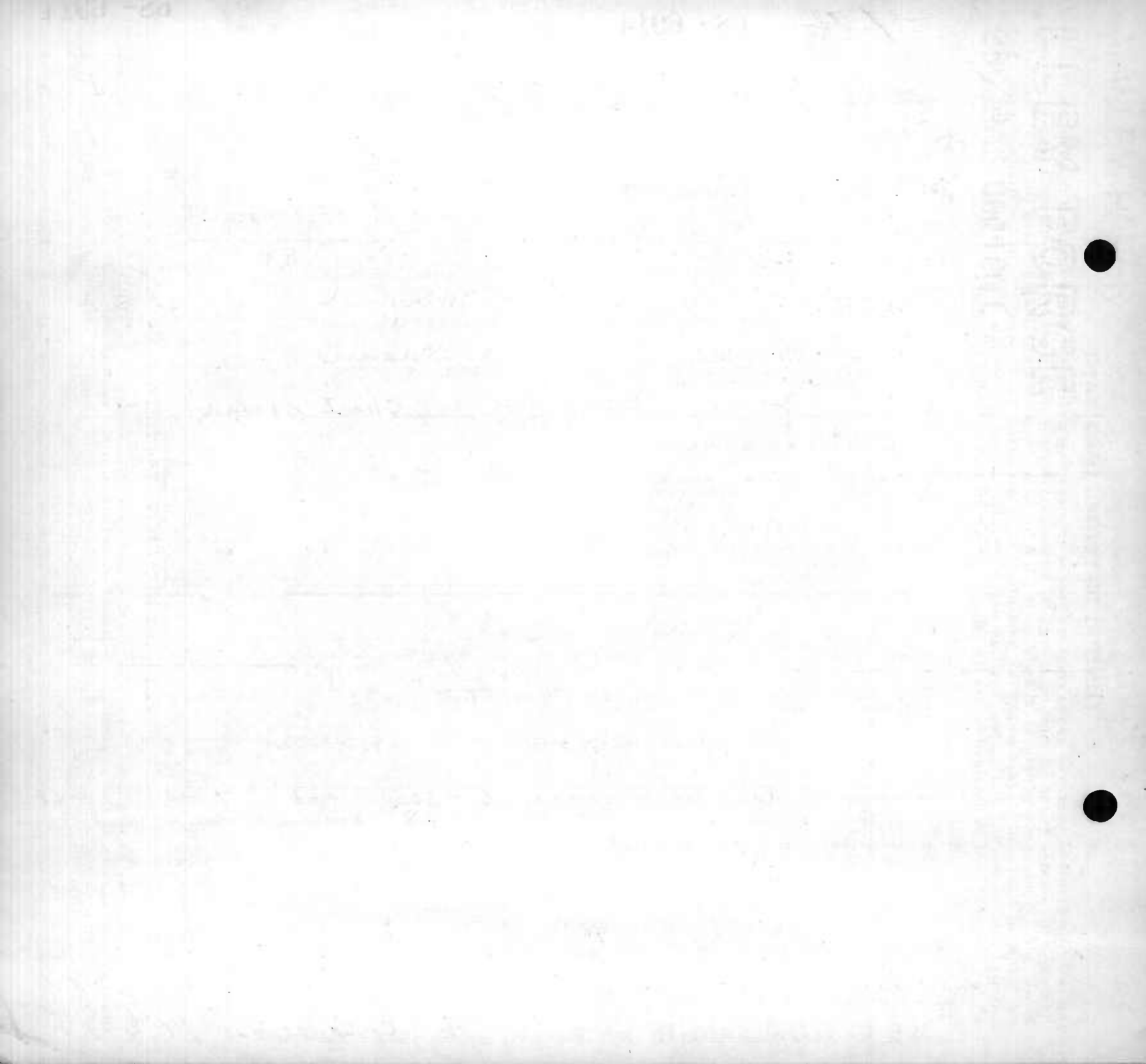
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6913	
<div>W-300 68- 6913</div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Margret Wood		July 3, 1968 6.05 Am. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 3501 Elm Ave.			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3501 Elm Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 13, 1884	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		Home	Va.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Ashley King			Posey		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		451-24-8466	Frances M. Johnson 3501 Elm Ave.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis					
(B) Antithrombotic cerebrovascular Dis					
(C)					
332X II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1963 to July 3 1968, that (I) (we) last saw the deceased alive on June 15 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward L. Glassman, MD				7/3/68	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
EDWARD L. GLASSMAN MD				4037 Falls Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-6-1968		Druid Ridge	
24D. LOCATION (City, town, or county)		24E. STATE		24F. ZIP CODE	
Pikesville, Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1968		Robert E. Taylor		Frank A. Seitz 814 W 31st St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-552		68-6914		BALTIMORE CITY HEALTH DEPARTMENT		68-6914	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Simmons, James Guy</i>				2. DATE AND HOUR OF DEATH <i>7-4-68</i> <i>8:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <i>213 S. Gilmer St.</i>			
5. SEX <i>Male</i>	6. RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-30-80</i>	9. AGE (In years lost birthday) <i>88</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Union Local 1355</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Simmons</i>				14. MOTHER'S MAIDEN NAME <i>Susan</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220-12-8955</i>		17. INFORMANT <i>Chart record</i>		ADDRESS	
18. <i>43671</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>C. V. A.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>331X II</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-30-68</i> to <i>7-4-68</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>7-4-68</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <i>J. Lee M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-4-68</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. Lee M.D.</i>				23D. ADDRESS <i>Franklin Square Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/8/68</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Combedge Ind.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan</i>		ADDRESS <i>Sun Belt Rd</i>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 5-421				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 68- 6915	
1. NAME OF DECEASED (Type or Print) SCHLOSSBERG, Irving nmi				2. DATE AND HOUR OF DEATH 7-3-68		3:20 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY BALTIMORE CITY		53.00	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1013 PARK VALLEY ROAD							
5. SEX MALE	6. RACE CAUCASION	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-11	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR			10B. KIND OF BUSINESS OR INDUSTRY KEYSER ALUMINUM		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIE SCHLOSSBERG				14. MOTHER'S MAIDEN NAME MINNIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 12-8-43 TO 9-7-45		17. INFORMANT MRS. ANN		ADDRESS SCHLOSSBERG	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 162.1 + 250.9 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 162.1 II				CAUSE OF DEATH 1013 PARK VALLEY ROAD (A) IMMEDIATE CAUSE BRAIN METASTASIS DUE TO, OR AS A CONSEQUENCE OF: (B) BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 TO 4 WEEKS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 11 JUNE 19 68 to 3 JULY 19 68 , that (X) (we) last saw the deceased alive on 3 JULY 19 68 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Elmo M. Gayoso</i>				23B. DATE SIGNED 7-3-68			
23C. PHYSICIAN'S NAME (Type) ELMO M. GAYOSO				23D. ADDRESS 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-68		24C. NAME of CEMETERY or CREMATORY (AITZ CHAIM) ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6916
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ROSE KRAFT		2. DATE AND HOUR OF DEATH 7-3-68 - 6:15 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL BALTIMORE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO 53-00 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6970 MARSUE DR. 15		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-7-07	9. AGE (In years last birthday) 60 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY SAMOVITZ		
14. MOTHER'S MAIDEN NAME YETTA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. HERBERT KRAFT, 6970 MARSUE DRIVE, APT. 1-B BALTIMORE 21215		
18. CAUSE OF DEATH				
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10.9 I CARDIOGENIC SHOCK				
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myocardial Infarction Arteriosclerotic heart disease.				
18C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 4/20.1 II Rheumatic heart disease & mitral stenosis				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 3, 1968 to July 30, 1968 and that (I) (we) last saw the deceased alive on July 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Wilhelmina P. Cafugan		23B. DATE SIGNED 7/3/68		23C. PHYSICIAN'S NAME (Type) WILHELMINA P. CAFUGAN
23D. ADDRESS SINAI HOSP. OF BALTIMORE		24. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-5-68		24C. NAME OF CEMETERY or CREMATORY HAR ZION
24D. DATE REC'D BY HEALTH DEPT. JUL 8 1968		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD

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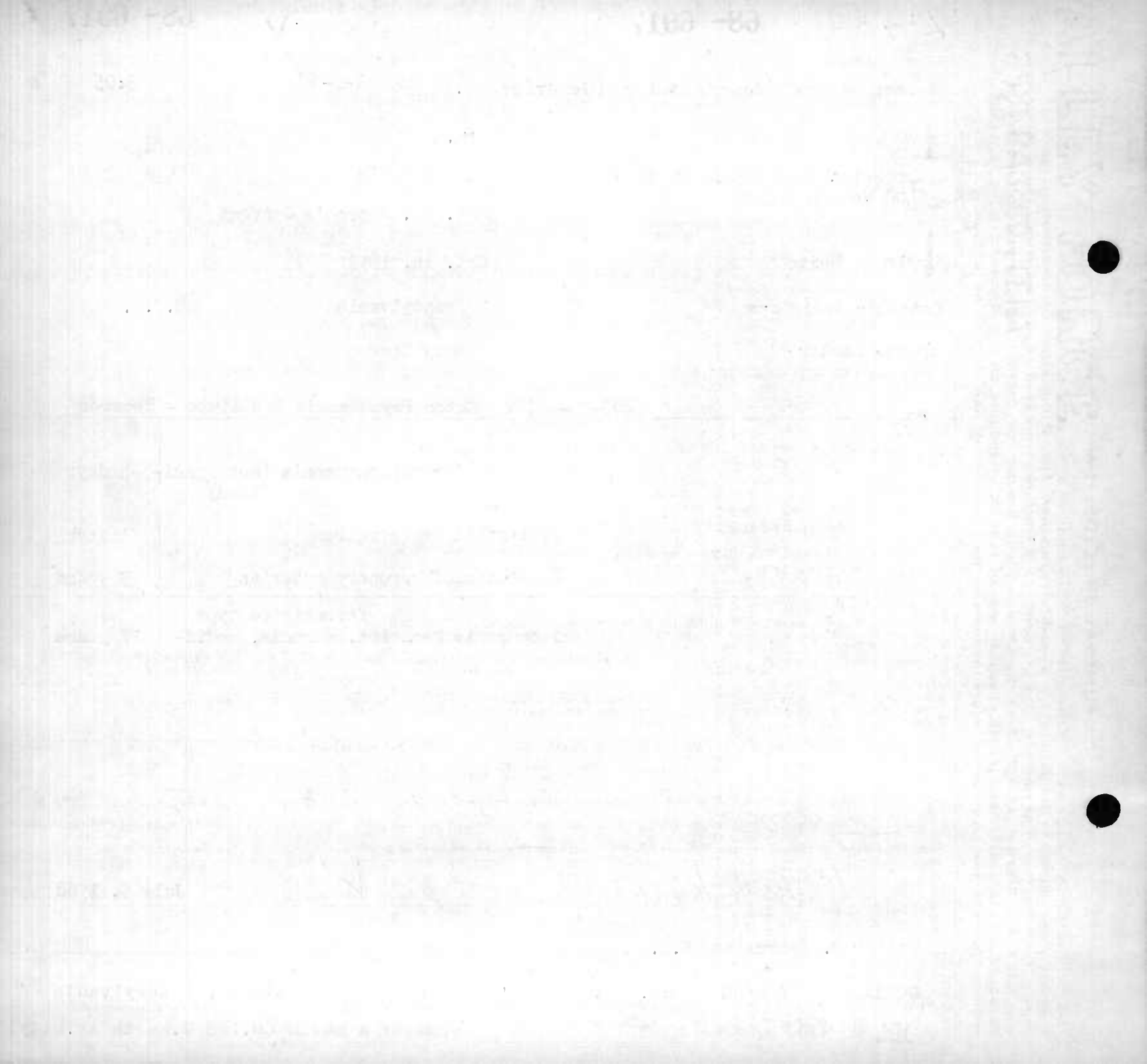
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FUNERAL DIRECTOR: IMPORTANT

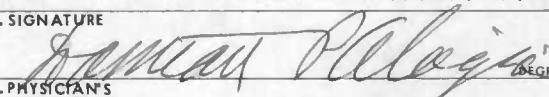
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6917	
L-460		68- 6917		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sister Gertrude Joseph Lawler (Genevieve A.)		2. DATE AND HOUR OF DEATH 7-5-68 3:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pa. B. COUNTY V-35		C. CITY OR TOWN Philadelphia D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6400 Wabash Avenue		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER Mt. St. Joseph's Convent	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1892	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Catholic Religious		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Lawler		14. MOTHER'S MAIDEN NAME Mary Condon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 203-40-6078T		17. INFORMANT ADDRESS Seton Psychiatric Institute - Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 412.4 I Br. Bronchopneumonia (not specified)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Myocardial degeneration DUE TO, OR AS A CONSEQUENCE OF:		1 year	
		(C) Sclerosis of coronary arteries DUE TO, OR AS A CONSEQUENCE OF:		3 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II Schizophrenic Reaction, chronic, undifferentiated type				27 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Sept. 19, 19 41 to July 19 68 , that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Walter D. Jahrreiss M.D.		23B. DATE SIGNED July 5, 1968			
23C. PHYSICIAN'S NAME (Type) Walter D. Jahrreiss M.D.		23D. ADDRESS Seton Institute			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/68		24C. NAME of CEMETERY or CREMATORY Mt. St. Joseph's Cemetery	
24D. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Farkas	
25C. FUNERAL DIRECTOR ADDRESS STEWART & MOWEN CO. 108 W. North Av. Cityl					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
P-625		68-6918		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Sister Clothilde Parisien		July 4, 1968		2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael 4000 Forest Hill Road Baltimore, Maryland 21207		A. STATE		B. COUNTY	
		Maryland		City	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4000 Forest Hill Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	
F.	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 19, 1878	90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress (retired)		Sister of Charity		Toronto, Canada	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Romuald Parisien			Ann Plamondon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		219-54-0665-J1		Sister Andrea	
				same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		10 days	
		Cerebral Thrombosis			
		(B) DUE TO, OR AS A CONSEQUENCE OF:		13 years	
General Arteriosclerosis					
(C) _____					
332 X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from February, 1955 to July 4, 1968, that (I) (we) last saw the deceased alive on July 2, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Damian P. Alagia, M.D.				3326 Frederick Ave., Baltimore 21228	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		7/8/68		Seton Inst. Cemetery on grounds of Seton Inst., City.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1968		R. E. F. F. F.		STEWART & MOWEN CO. 108 W. North Av. Cityl	

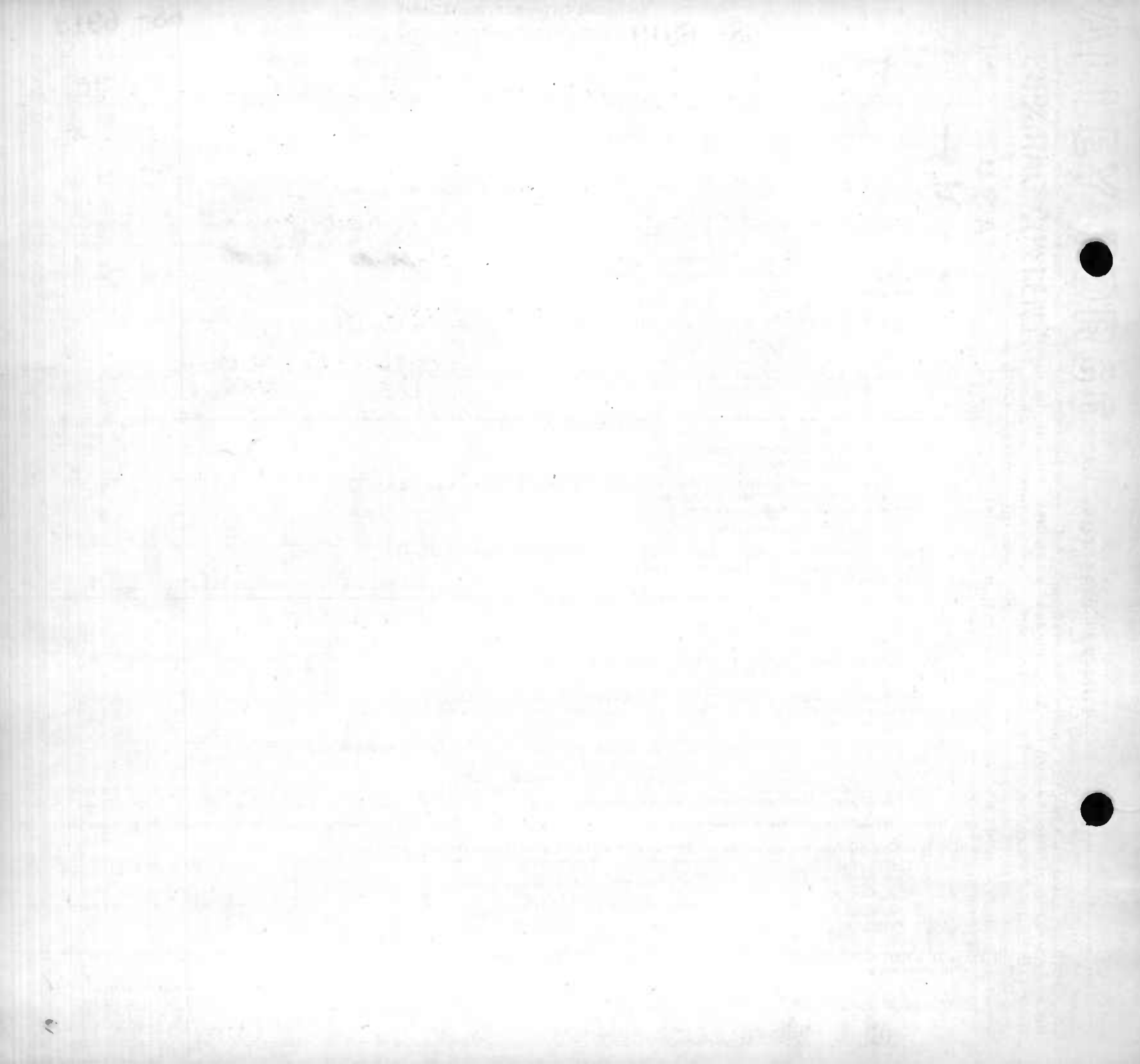
62-6915

Handwritten signature or name, possibly "K. M. [illegible]".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6919
<p>W-425 68-6919</p> <p>BIRTH NO.</p>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		
<p>1. NAME OF DECEASED (Type or Print) Elsie J. Wilson.</p>		<p>2. DATE AND HOUR OF DEATH 7-4-68 6:35 A.M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Melchor N. Home 102327 N. Charles ST. Balt., Md.</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Balto. Md B. COUNTY Balto. Md C. CITY OR TOWN Balto. Md D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1307 Winston AVE</p>		
<p>5. SEX f.</p>	<p>6. RACE C</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 5-6-1908</p>	<p>9. AGE (In years last birthday) 60</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY —</p>		
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A</p>		
<p>13. FATHER'S NAME James H. Quickley</p>		<p>14. MOTHER'S MAIDEN NAME Rebecca V. Howard</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. NO RE</p>		<p>17. INFORMANT MRS. Rebecca Sinkfield - daughter</p>
<p>18. 4369 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Branchopneumonia</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 das.</p>		
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Aspiration</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: 2 das</p>		
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 331X II Generalized Arteriosclerosis</p>		<p>(C) Old and new strokes (CVA) years(?)</p>		
<p>19A. DATE OF OPERATION 6</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) No</p>
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from 8-11-1968 to 7-4-1968, that (I) (we) last saw the deceased alive on 7-4-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE Cesar Valle Caverio</p>		<p>23B. DATE SIGNED 7-5-68</p>		<p>23C. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERIO M.D.</p>
<p>23D. ADDRESS 8629 Liberty Rd.</p>		<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		
<p>24B. DATE 7/8/68</p>		<p>24C. NAME OF CEMETERY or CREMATORY Mt. Zion</p>		<p>24D. LOCATION (City, town, or county) (State) Longgreen, Balto. Co. Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968</p>		<p>25B. NAME OF REGISTRAR Robert E. Fairbanks</p>		<p>25C. FUNERAL DIRECTOR Wm. L. Clatman</p>
<p>ADDRESS 1701 M. E. Culbertson Balt., Md</p>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
<div style="display: flex; justify-content: space-between;"> W-425 68- 6920 CERTIFICATE OF DEATH </div>				<div style="display: flex; justify-content: space-between;"> 68- 6920 REG. NO. </div>
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		Stanley Wilson		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH		
		7-2-68 9:30 p. M.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY		
Provident Hospital 1514 Division St Baltimore, Maryland		<div style="display: flex; justify-content: space-between;"> Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>		
5. SEX		6. RACE		
Male		Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-16-98		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years lost birthday)		
Retired JANITOR BALTO. CITY		70		
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
		Harford, Maryland		
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?		
JOHN E. WILSON		USA.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
NO		215-18-3285		Mrs. Edith Jackson - niece Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES		Bronchopneumonia, bilateral		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		Anteriosclerosis, generalized		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Rupture of gastric artery w/ large hemorrhage		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
4-3-0-0 II				Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from June 29, 19 68 to July 2, 19 68, that (I) (we) last saw the deceased alive on July 2, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Humberto V. Centzand				
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS
Humberto V. Centzand				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		7/6/68		St. Lukes
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
JUL 8 1968		Robert E. Taylor		Wm. L. Chatham 1701 Mt. Cullloch St

1 D-132 68-6921 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6921

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour	
		JAMES DEBADTS		July 3, 1968				10:50 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
<u>42</u> Sinai Hospital				July 3, 1968				10:50 P.M.	
6. SEX				7. RACE		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Finksburg		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER			
12/1/43		24				Codd Mobile Ville - Route 140			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
New York				U.S.A.		Adrian DeBadts			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Printer				Forman-Pierson Press		Minnie ?			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS			
No				113-34-7868		Elmer A Mitchell Littlestown Pa.			
19. <u>E 815.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Multiple blunt injuries</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>					
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED					
6-29-68 2:16 A.M.				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				22F. HOW DID INJURY OCCUR?					
Green Spring Avenue				Intersection of Woodland Road <u>27-15</u>					
22F. HOW DID INJURY OCCUR?				Auto-fixed object collision					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED	
<u>Charles S. Springate</u> M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				July 4, 1968	
EXAMINER'S NAME (Type)				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		7/6/68		Garden Of Faith Cem.		Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 8 1968 <u>Robert E. Taylor</u>						Lassahn Funeral Home 7401 Belair Rd.			

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512 68-6922		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6922	
1. NAME OF DECEASED (Type or Print) CLEM THOMPSON		2. DATE AND HOUR OF DEATH JULY 1, 1968 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HARFORD C. CITY OR TOWN SWAN COBBERK Aberdeen D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER SILVER LEE FARM			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-89	9. AGE (In years lost birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) Harford Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Thompson (D)		14. MOTHER'S MAIDEN NAME Susie Cullum (D)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 05 3335		17. INFORMANT ADDRESS Bertha Hammel, Peryman, Maryland 21130	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.9 I MYOCARDIAL INFARCTION 7 DAYS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 420.1 II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 23 1968 to JULY 1 1968 , that (we) lost saw the deceased alive on JULY 1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John R. Sobotka M.D.		23B. DATE SIGNED JULY 1, 1968		23C. PHYSICIAN'S NAME (Type) JOHN R. SOBOTKA M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-6-68		24C. NAME OF CEMETERY or CREMATORY Calvary Methodist Cemetery		24D. LOCATION (City, town, or county) (State) Churchville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Fairbairn		25C. FUNERAL DIRECTOR Tarring Funeral Home	
				25D. ADDRESS Aberdeen, Md. 21001	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 6923	
H-240				68- 6923	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Helen D. Hassell			July 2, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
00 2950 Arunah Ave.			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2950 Arunah Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Female	Col.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 7, 1910	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife			Balto. Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Driver			Carrie Wilson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
no					Bertha Driver 1306 Mosher St.
18. 2877X I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
			Coronary occlusion		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic cardiovascular disease		
			undet		
			(C) Obesity		
			undet		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10-4 19 55 to 6-18 1968, that (I) (we) last saw the deceased alive on 6-18 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
John T. Chissell			7-2-68		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
John T. Chissell			1038 Edmondson Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			7/6/1968		
24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Mt. Auburn Cem.			Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
JUL 8 1968			R. E. 2, Jr.		
25C. FUNERAL DIRECTOR			ADDRESS		
Williams Funeral Home			319 N. Schrock St.		

Anteriorly directed (intermaxillary)
chisel

1038 Edward - 4/18

John J. Churchill no

B-370

68- 6924

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6924

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CLARENCE BATES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 4 68 11:45 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 41 So. Pulaski St.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1968 11:45 a.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 20-63	
9. DATE OF BIRTH June 6, 1907		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elridge Bates		14. MOTHER'S MAIDEN NAME Emma Butler	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		16. KIND OF BUSINESS OR INDUSTRY Porter	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 212-01-9080	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 7-23-1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 412.4	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED July 5, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/1968	
24C. NAME OF CEMETERY or CREMATORY W. M. Kornblum Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Jones	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 3192 Schrock St.	

08-0321

08-0321

Elmer Bates
Elmer Bates

Perfor
Elmer Bates

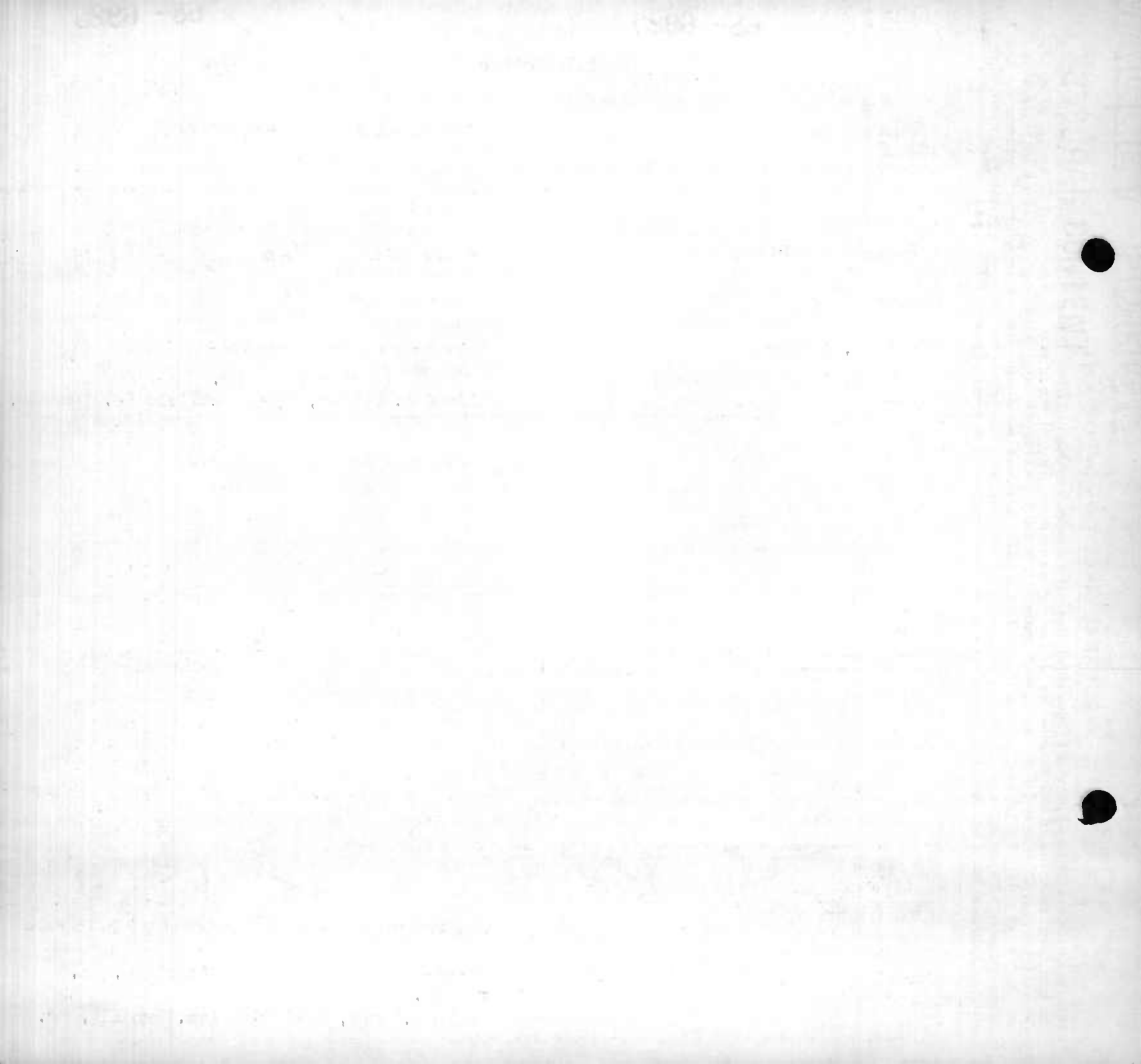
as shown in the photo of the book

Elmer Bates
Elmer Bates
Elmer Bates

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6925	
<div style="display: flex; justify-content: space-between;"> P-360 68-6925 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LUCILLE POTTER		2. DATE AND HOUR OF DEATH 7-5-68 7:51/68 4:45 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GENERAL HOSPITAL			C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 7546 WESTFIELD RD.		
5. SEX Female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-22-08	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David H. Potter			
14. MOTHER'S MAIDEN NAME ARMSTRONG, HANNA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. ?		17. INFORMANT (Husband) Md. Eldred A. Potter, 7546 Westfield Rd, Dundalk,			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) TERMINAL METASTATIC C.A. OF COLON		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 153.8 II					
19A. DATE OF OPERATION 2-28-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA COLON & METAS		20A. AUTOPSY? (Yes or No) -	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 7-1-1968 to 7-5-1968 , that (I) (we) last saw the deceased alive on 7-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Prinya Timonokol</i>		23B. DATE SIGNED 7-5-68		23C. PHYSICIAN'S NAME (Type) PRINYA TIMONOKOL	
23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/68		24C. NAME OF CEMETERY OR CREMATORY Collierstown Presbyterian Church Cem.	
24D. LOCATION Collierstown, Va.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			



BIRTH NO.		1. NAME OF DECEASED (Type or Print) EARL M. WHITE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> July 3, 1968 6:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2023 Christian Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1968 6:55 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 20-03	
6. SEX male	7. RACE white	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 12/17/1911		10. AGE (In years last birthday) 56	E. STREET AND NUMBER 2023 Christian Street		
11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Weightell W.M. White	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		14B. KIND OF BUSINESS OR INDUSTRY Restaurant		15. MOTHER'S MAIDEN NAME Lillie J. Orem	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes navy Peace Time		17. SOCIAL SECURITY NO. 213-14-3928		18. INFORMANT Mr. Edward W. White 2904 Kingsley St	
19. CAUSE OF DEATH 508.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration of Stomach Contents (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20-03			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/6/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/68	24C. NAME OF CEMETERY or CREMATORY Green Haven Cem.		24D. LOCATION (City, town, or county) (State) Pitkin Hwy Glen Burnie Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Edwards		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc. ADDRESS 901 Hollins St. 23. Md.	

00-88-00

00-88-00



R-360

68-6927

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-6927

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JULIA V. RIDER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

7

3

68

12:35 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(If not in hospital or institution, give street
address or location)

00

138 S. Clinton St. # 21224.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July

3

1968

12:35 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Aug. 14, 1893

10. AGE (In years
lost birthday)

74

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

138 S. Clinton St. # 21224.

11. BIRTHPLACE (State or foreign country)

Sanford, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Hinman

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

House Work

15. MOTHER'S MAIDEN NAME

Kandala Shaw

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

212-12-9370

18. INFORMANT

Teagle L. Byrd : Baltimore, 21222, Md.

6528 Riverview Ave.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Hypertensive arteriosclerotic cardiovascular
disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 3, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-6-68.

24C. NAME of CEMETERY or CREMATORY

Moreland Memorial Park

24D. LOCATION (City, town, or county) (State)

2901 Taylor Ave. Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1968

25B. NAME OF REGISTRAR

Robert E. Fiedler

25C. FUNERAL DIRECTOR

Charles S. Seiler

901 S. Conkling St.
Balto., 21224, Md.

68-6987

68-6987

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6928
11-235		68-6928		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) J. Susan McDonald		
2. DATE AND HOUR OF DEATH July 6, 1968		1206 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Balto. Highlands D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2910 Illinois Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 19, 1883	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Blue Nob, Blair Cty., Pa
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Noel		
14. MOTHER'S MAIDEN NAME Elizabeth Ernst		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		
16. SOCIAL SECURITY NO. 214-54-7582		17. INFORMANT Mrs Madeline Fowler ADDRESS 2910 Illinois		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 + 250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion of myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: ? (C) ?		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		Shapeless Mellitus		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 24, 1968 to July 6, 1968 , that (I) (we) last saw the deceased alive on June 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Earl Cassel		23B. DATE SIGNED 7-6-68		23C. PHYSICIAN'S NAME (Type) Earl Cassel
23D. ADDRESS 4001 Wickers Ave		23E. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 10, 1968	24C. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery Hollidaysburg, Penna.	24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Earling Funeral Estate ADDRESS 736 Edmondson Ave. Catonsville, Md. 21228		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6929
BIRTH NO. D-000		68-6929		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Katie A. Day		2. DATE AND HOUR OF DEATH 7-3-68 1:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 627 W. 33rd St.		
5. SEX Female	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-15	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOSEPH MAGAHA		
14. MOTHER'S MAIDEN NAME LAVINIA YEAGER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		
16. SOCIAL SECURITY NO. NONE		17. INFORMANT BORTNER C. DAY ADDRESS 627 W. 33RD ST		
18. 1829 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure 2 1/2 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma of uterus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 174X II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from 6-22-1968 to 7-3-1968 , that (I) (we) last saw the deceased alive on 7-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Scimit Komjathkul M.D.		23B. DATE SIGNED 7/13/68		23C. PHYSICIAN'S NAME (Type) TENINT KOSIVATAKUL M.D.
23D. ADDRESS Lutheran Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 7/6/68		24C. NAME of CEMETERY or CREMATORY PINE GROVE		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR P. E. J. J.		25C. FUNERAL DIRECTOR Paul E. J. J. ADDRESS 345 Chestnut Ave

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		68- 6930		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6930	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) DAILEY, Anna H.				2. DATE AND HOUR OF DEATH July 4/68 2 ¹⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue, Baltimore, Maryland				C. CITY OR TOWN White Marsh		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F				6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Joseph. Schlebowski				14. MOTHER'S MAIDEN NAME Eva (UNK)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 260X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Infected (C) above have reputation				CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF: (B) Hypostatic pneumonia 3-4 days DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes, generalized atherosclerosis years.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH inst.	
19A. DATE OF OPERATION May 4/68				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Removal of thrombus		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-31-1968 to July 4 1968, that (I) (we) last saw the deceased alive on July 4 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George P. Konok M.D. M.Sc.				23B. DATE SIGNED July 4/68		23C. PHYSICIAN'S NAME (Type) George P. Konok M.D. M.Sc. (Surgeon)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/8/68		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968				25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR Robert C. Altenburg Funeral Home, Inc. 6009 Hanford Rd. - Balto., Md. 21214	
24D. LOCATION Baltimore, Maryland				24E. ADDRESS Baltimore City Hospitals 4940 Eastern Ave., Baltimore Md.			

M-460

68- 6931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68- 6931

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

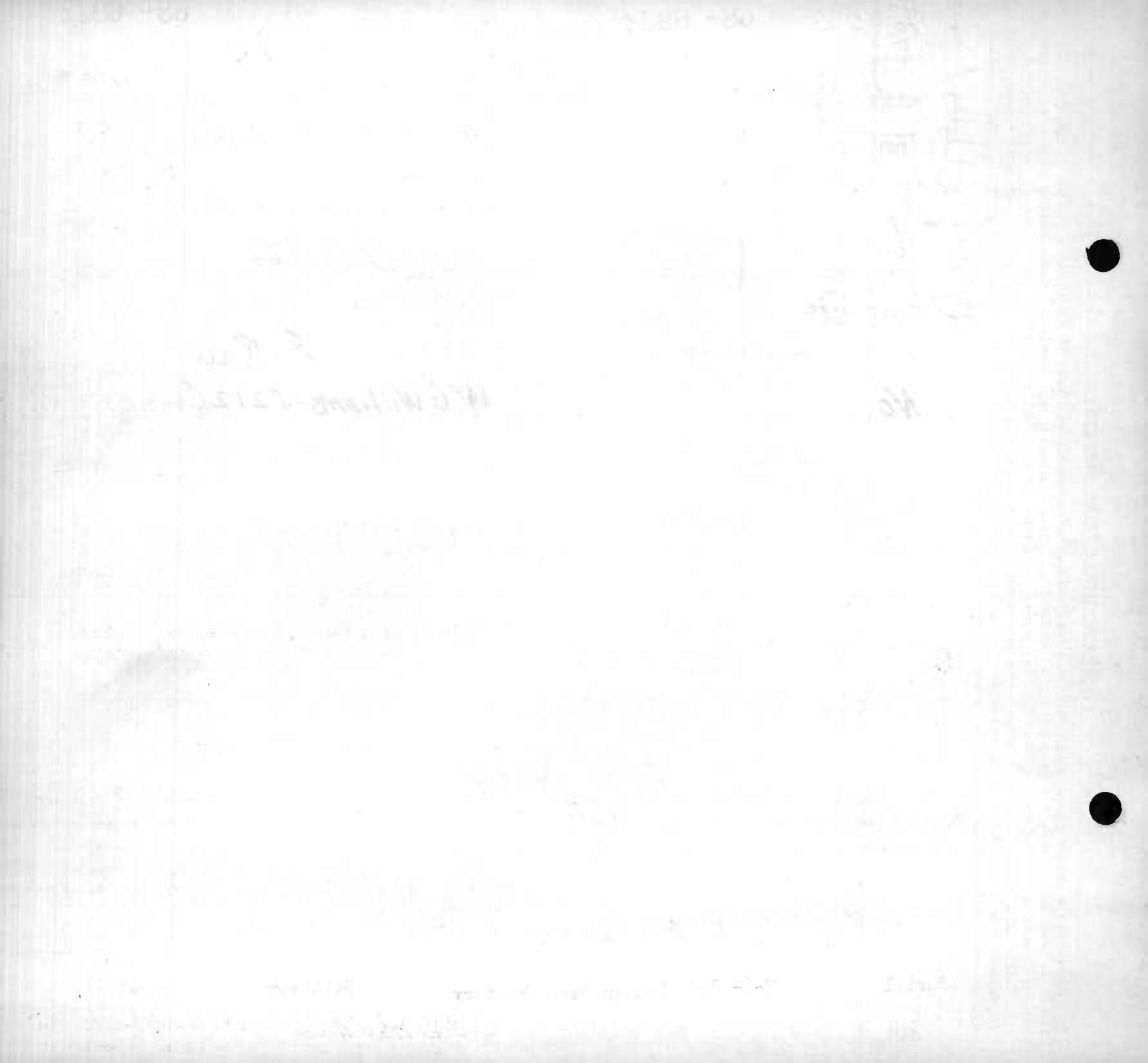
BIRTH NO.		68- 6931		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Miller, Annie F.</i>				2. DATE AND HOUR OF DEATH <i>7/3/68</i> <i>220</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1-01</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> <i>1940 Eastern Ave.</i> <i>Baltimore, Md. # 21224</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>918 Potomac Street</i>		<i>21224</i>	
5. SEX <i>Female</i>	6. RACE <i>Whit</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-1-86</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Fooks</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Ritter</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>BCH: Records 4940 Eastern Ave Baltimore, Md.</i>		ADDRESS <i>#21224</i>	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia, Cardio Resp. ARREST</i> (B) <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>UTI, Decub ULCERS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 mos</i> <i>1 mos</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>331X II</i> <i>DECUBITUS ULCERS</i>							
19A. DATE OF OPERATION <i>5/20/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>anterior prostatectomy</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) —		21C. WHERE DID INJURY OCCUR? —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from <i>5/11/68</i> 19 to <i>7/3/68</i> 19 that (I) (we) last saw the deceased alive on <i>7/3/68</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Bruce D. Snyder MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>7/3/68</i>	
23C. PHYSICIAN'S NAME (Type) <i>BRUCE D. SNYDER MD</i>		23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Ave. Baltimore, Md. # 21224</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-6-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Schwartz Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE DEATH REPORTED <i>JUL 8 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Jones</i>		25C. FUNERAL DIRECTOR <i>Nicholas T. Matthews</i>		ADDRESS <i>3021 Eastern Ave, Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

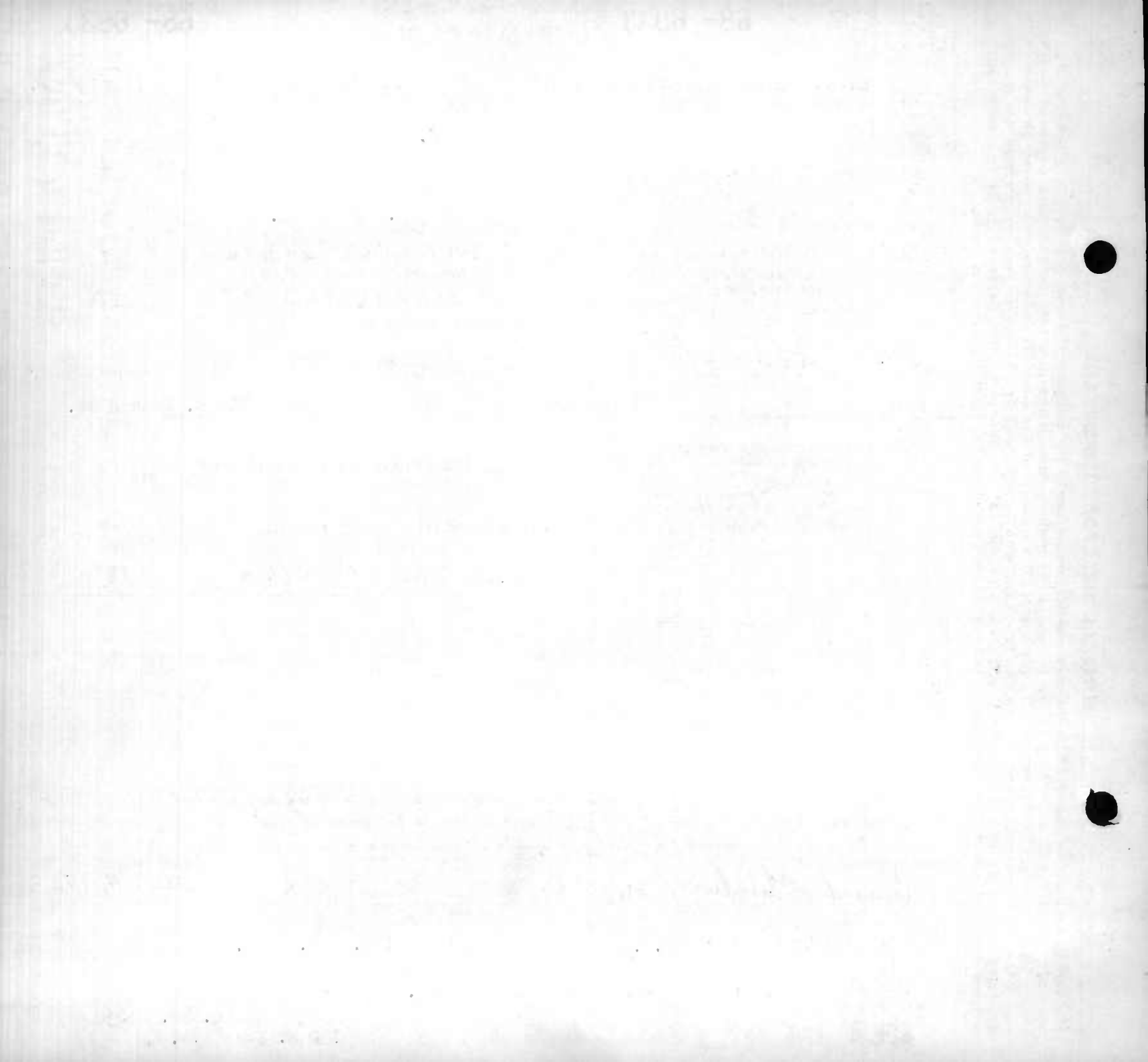
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6932	
W-452 68-6932					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) WILLIAMS, MRS. MARIE A.			2. DATE AND HOUR OF DEATH 7-3-68 11:06 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 5212 CROMARTY ROAD		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/04	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN T. HENKEL		
14. MOTHER'S MAIDEN NAME AUGUSTINE E. ROLL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT W. G. WILLIAMS-5212 Cromarty Rd		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE M.I. (B) CROMARTY IN SUFFICIENTLY PROMPT DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) FATTY METAMORPHOSIS OF LIVER		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from JULY 2 19 68 to JULY 3 19 68 , that (I) (we) last saw the deceased alive on JULY 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. A. ALBUQUERQUE			23B. DATE SIGNED JULY 3, 1968		
23C. PHYSICIAN'S NAME (Type) MARCELO F. ALBUQUERQUE			23D. ADDRESS BON SECOURS HOSP.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1968		24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery	
24D. LOCATION Baltimore, Maryland.		24E. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
24F. NAME OF REGISTRAR Paul E. Farnham		24G. FUNERAL DIRECTOR E. S. McNeil			
24H. ADDRESS 301 Frederick Rd Baltimore Md					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6933
BIRTH NO. R-152 1. NAME OF DECEASED (Type or Print) BABY GIRL RABENSTEIN		CERTIFICATE OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL HOSPITAL		2. DATE AND HOUR OF DEATH JULY 3, 1968 11⁰⁵ P.M. 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 126 W. Ostend St.		
5. SEX Female	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1968 9. AGE (In years last birthday) < 1 day old 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE 10B. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jack Rabenstein 14. MOTHER'S MAIDEN NAME Lillian Wolford		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NONE		17. INFORMANT Lillian Wolford ADDRESS 126 W. Ostend St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 762.0 I RESPIRATORY FAILURE (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES PEREBRAL ISCHEMIA DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE RESPIRATORY FAILURE 15 min. DUE TO, OR AS A CONSEQUENCE OF: (B) PEREBRAL ISCHEMIA 18 hr. 55 min. (C) PERINATAL ASPHYXIA 18 hr. 55 min.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 762.0 II				
19A. DATE OF OPERATION NONE 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) --- 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---		
21D. TIME OF INJURY (APPROX.) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? ---		
22. I certify that (I) (this hospital) attended the deceased from JULY 3 19 68 to JULY 3 19 68 , that (I) (we) last saw the deceased alive on JULY 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Raymond Gambrill 3rd M.D.		23B. DATE SIGNED JULY 4, 1968		23C. PHYSICIAN'S NAME (Type) Raymond Gambrill 3rd M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68 24C. NAME OF CEMETERY or CREMATORY Majestic Kentucky Cem. 24D. LOCATION Kentucky		
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Johnson 25C. FUNERAL DIRECTOR McClary F. H. ADDRESS Balto. Md. 21230		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

68- 6934 CERTIFICATE OF DEATH

REG. NO. 68- 6934

BIRTH NO. 5-530

1. NAME OF DECEASED (Type or Print) MR. ALEX SMITH		2. DATE AND HOUR OF DEATH JULY 3, 1968 1:05 P.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 123 SOUTH CENTRAL AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY UNEMPLOYED	9. AGE (In years last birthday) 78
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BILLY SMITH		14. MOTHER'S MAIDEN NAME BELLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 401 18 2375	
17. INFORMANT		ADDRESS	
18. 412.34-571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction Coronary Artery Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes weeks years	
19. DATE OF OPERATION 420.0 II		20. AUTOPSY? (Yes or No) ALCOHOLIC CIRRHOSIS HYPOPROTEINEMIA	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-2 1968 to 7-3 1968 , that (I) (we) last saw the deceased alive on 7-3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE A. E. SUBORG, JR.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. A. E. SUBORG, JR.		23D. ADDRESS Church Home + Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-68	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Walter Dabrowski	
25C. FUNERAL DIRECTOR Walter Dabrowski		25D. ADDRESS 1005 Dundalk Avenue	

VS 150-REV. 1/1/68

ALCOHOLIC CHLORIDE
HYPERATOMIC

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH F. LIVERMAN LIVERMON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 5, 1968 Hour 4:25 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 509 Sheridan Avenue (DOA) 179/68		3. DATE PRONOUNCED DEAD Month Day Year July 5, 1968 Hour 4:25 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH January 2, 1909		10. AGE (In years lost birthday) 59 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 509 Sheridan Avenue	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Livermon John August Livermon	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary E. Robinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No ---		17. SOCIAL SECURITY NO. 212-07-7863		18. INFORMANT Livermon Mary C. Livermon (Wife) Same ADDRESS	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 5, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 8, 1968		24C. NAME of CEMETERY or CREMATORY Holly Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR R. E. F. F. F.	
25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Baltimore, Md. 21212		25D. ADDRESS			

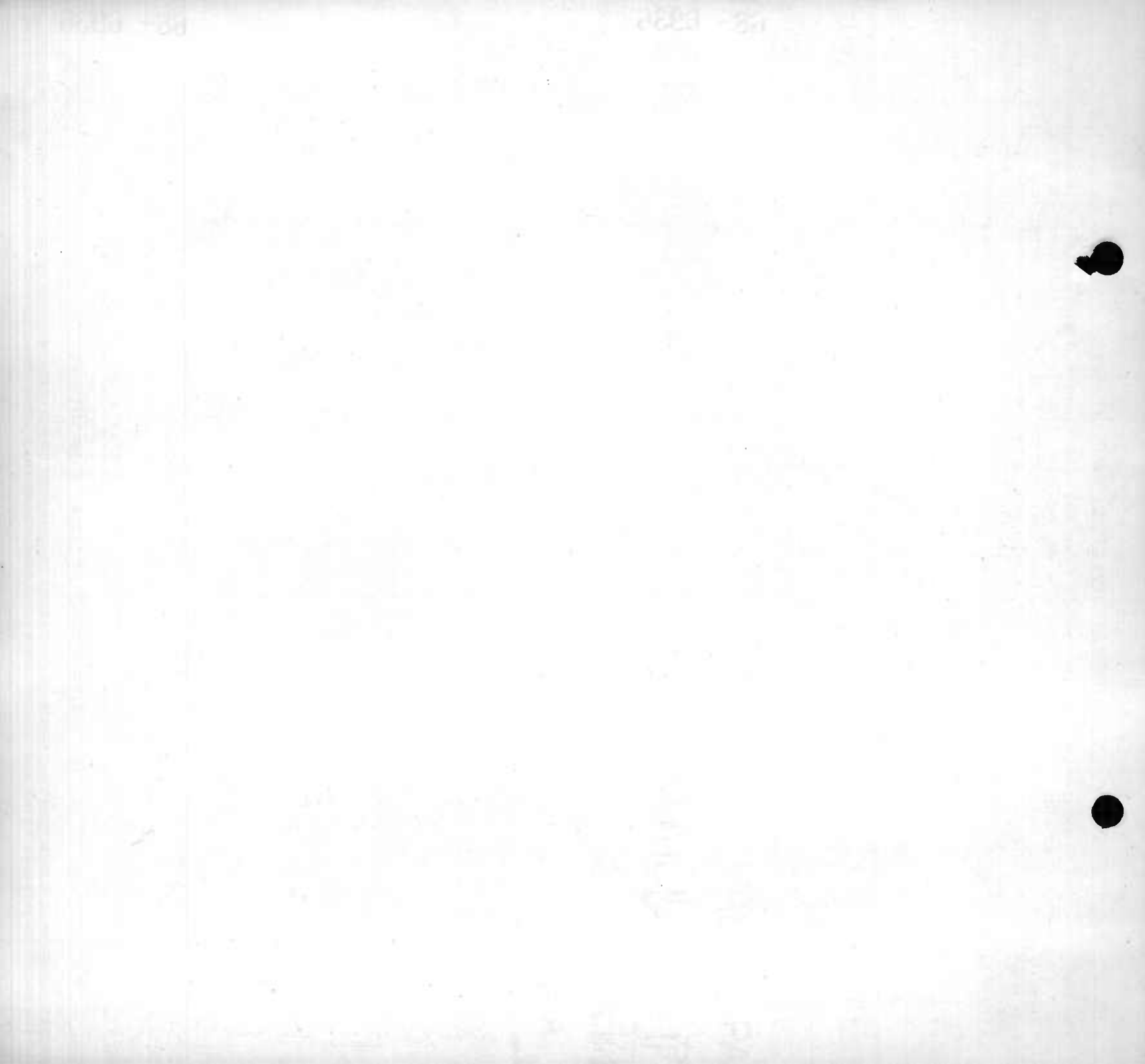
Baptismal record for Joseph Francis Liverm~~on~~, born 1/2/09 and bapt. 1/10/09

CERTIFICATE AMENDED

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>68-6936</u> <u>4</u>	
5-163 68-6936		BIRTH NO. <u>68-12128</u>	
1. NAME OF DECEASED (Type or Print) <u>Patrick Michael Seifert</u>		2. DATE AND HOUR OF DEATH <u>July 3, 1968</u> <u>3:00</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Ind. Gen. Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1903 Harman Ave</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1968</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baby</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>8</u> <u>20</u> If Under 1 Yr. Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Francis Seifert</u>		14. MOTHER'S MAIDEN NAME <u>LaVelle Dolores Cronise</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>LaVelle Seifert</u>		ADDRESS <u>1903 Harman Ave</u>	
18. <u>776.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>773.0 II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hyaline Membrane Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Yes</u>	
20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>WHERE DID INJURY OCCUR?</u> (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> <u>1968</u> to <u>July 3</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>July 3</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Song. S. Chung</u>		23B. DATE SIGNED <u>7/3/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>—</u>		23D. ADDRESS <u>Maryland General Hospital, Balt. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/5/1968</u>	
24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Seifert</u>	
25C. FUNERAL DIRECTOR <u>John J. Conway & Son, Inc.</u>		ADDRESS <u>901 Hallam St. Balt. Md.</u>	



1-545 68-6937 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68-6937

BIRTH NO. REG. NO.

1. NAME OF DECEASED (Type or Print) MELVIN THONLIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 30, 1968	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1021 N. Calhoun Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 30, 1968 12:53 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1896 10. AGE (In years last birthday) 72		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) VIRGINIA		E. STREET AND NUMBER 1021 N. Calhoun Street	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME ?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 217-01-2968		18. INFORMANT MRs Lillian Smith, 919 Edmondson	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 30, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68	
24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County M	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Adolphus Halstead	
25C. FUNERAL DIRECTOR 1206 W North			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

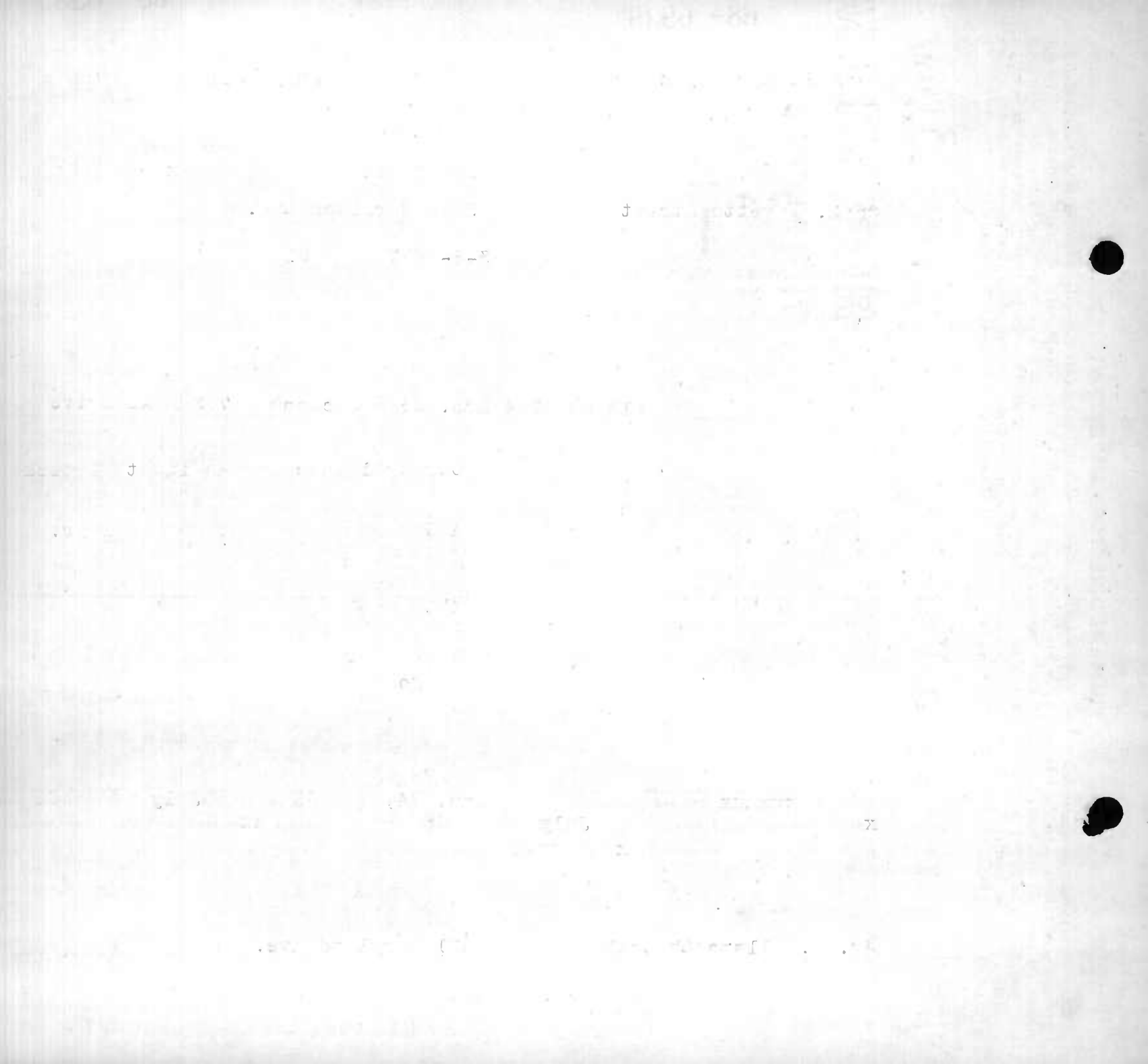
1. NAME OF DECEASED (Type or Print) CLARENCE HARVEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 26 68 8:40 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 819 Pierce St.		3. DATE PRONOUNCED DEAD Month Day Year Hour June 26 1968 8:40 a.m.	
6. SEX Male		7. RACE Colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1906		10. AGE (In years lost birthday) 62	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U S A	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 229-07-6182	
18. INFORMANT Mrs McCaine		ADDRESS 742 Peirce St	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 26, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68	
24C. NAME OF CEMETERY or CREMATORY Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Talbot	
25C. FUNERAL DIRECTOR Halstead		ADDRESS 1206 W North Ave	

WALLACE J. OHGIE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6935	
1. NAME OF DECEASED (Type or Print) Addie Spraggins			2. DATE AND HOUR OF DEATH July 3, 1968 10:30 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 70 1105 E. Fayette Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3625 Garrison Ave.		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1877	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OLD AGE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 213 54 0164		
17. INFORMANT Mrs. Joan Jackson			ADDRESS 753 Lake Drive		
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 yr.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (did not) attended the deceased from Jan. 24, 1968 to July 3, 1968 , that (I) (was) last saw the deceased alive on July 3, 1968 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 7/3/68	
23C. PHYSICIAN'S NAME (Type) Dr. E. Ellsworth Cook		23D. ADDRESS 2431 Maryland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/6/58		24C. NAME OF CEMETERY or CREMATORY M. Calvary Cemetery	
24D. LOCATION (City, town, or county) A A County M		24E. STATE M			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Halstead		25C. FUNERAL DIRECTOR A Halstead 1206 W North Ave	



1
G-651 68- 6940 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 68- 6940

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES GREENFIELD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month June Day 30 Year 1968 Hour 8:05 A.M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month June Day 30 Year 1968 Hour 8:05 A.M.	
6. SEX Male 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Charles Co. 58-00 C. CITY OR TOWN Bryant Town D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 2/28/49 10. AGE (In years last birthday) 19 11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER Bernard A. Greenfield	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Bernard A. Greenfield	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Magdalen Farmer	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Father Bryantown, Md.		ADDRESS	

19. E 816.1 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple blunt injuries DUE TO, OR AS A CONSEQUENCE OF:
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION 6-30-68		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Jones Wharf Road approximately 3 miles east State Rte. 235
22D. TIME OF INJURY (APPROX.) 6-30-68 1:18 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto that overturned

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **June 30, 1968**
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 3/68	24C. NAME OF CEMETERY or CREMATORY St. Mary's Ch. Cem.	24D. LOCATION (City, town, or county) (State) Bryantown, Charles Co. Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	25B. NAME OF REGISTRAR Robert E. [illegible]	25C. FUNERAL DIRECTOR ADDRESS Martell Adams Aquasco, Md.	

08-1910

08-1910

Richard A. Greenfield
Richard A. Greenfield
Richard A. Greenfield
Richard A. Greenfield

Richard A. Greenfield
Richard A. Greenfield

Richard A. Greenfield

Richard A. Greenfield
Richard A. Greenfield
Richard A. Greenfield
Richard A. Greenfield

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-6941

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM BURNETT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 7 Day 1 Year 68 Hour 3:45 a M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		3. DATE PRONOUNCED DEAD Month July Day 1 Year 1968 Hour 3:45 a M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Charles		C. CITY OR TOWN Hughesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER Hughesville, Maryland
9. DATE OF BIRTH No. 30, 1944	10. AGE (In years lost birthday) 23	11. BIRTHPLACE (State or foreign country) Mt. Olive, N. Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Jack Burnett	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Mary Robinson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 244-70-8751		18. INFORMANT Mary R. Young ADDRESS Rt. 1 - Hughesville, Md.	
19. E 9681 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injury		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: I	
(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). E 985 X II			
20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) YES
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk?	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 231 Patuxant City	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) June 30, 1968 11:08 P	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	22F. HOW DID INJURY OCCUR? Subject struck over head with plank of wood	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		DATE SIGNED July 1, 1968	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE July 6, 1968	24C. NAME OF CEMETERY or CREMATORY Bowdon Cemetery	24D. LOCATION (City, town, or county) (State) Bowdon, N.C.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	25B. NAME OF REGISTRAR Robert E. Fale, Jr.	25C. FUNERAL DIRECTOR ADDRESS Marshall Adams Aquasco, Md.	

68-6911

68-6911

Jack Burdett
Mary Robinson

Mr. J. W. Robinson

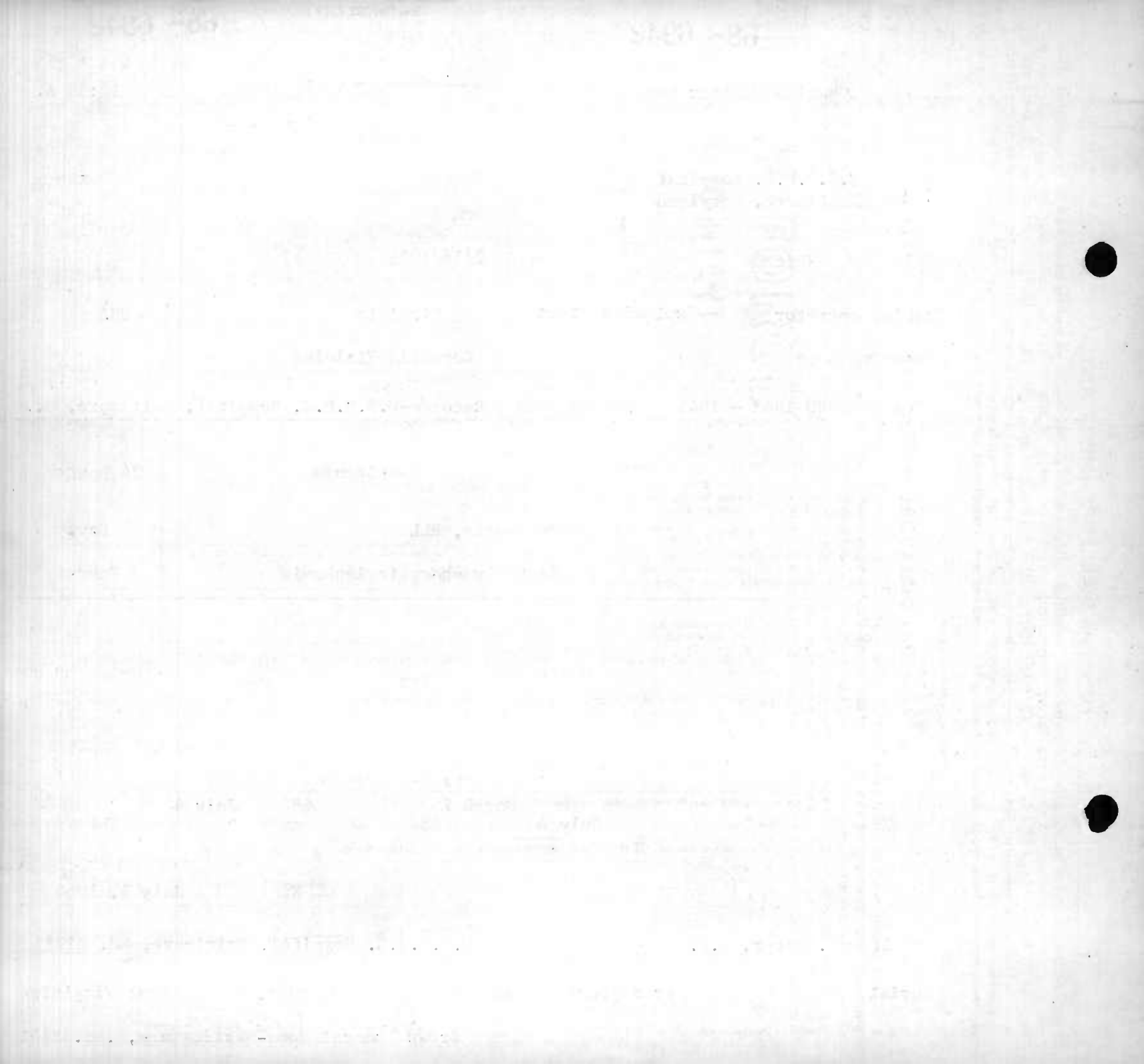
Robert

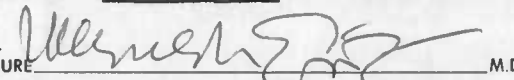
United States Bureau of Census
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6942	
<div style="display: flex; justify-content: space-between;"> L-000 68- 6942 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles William Laye		July 4, 1968 12:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE West Virginia B. COUNTY V-45		
FULL NAME OF HOSPITAL OR INSTITUTION 2X U.S.P.H.S. Hospital Baltimore, Maryland			C. CITY OR TOWN Inwood		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER Box 8		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1921	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator		10B. KIND OF BUSINESS OR INDUSTRY Explosive Plant		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Nicodemus Laye		
14. MOTHER'S MAIDEN NAME Cornelia Fielding			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1942 - 1945		
16. SOCIAL SECURITY NO. 254 28 5085			17. INFORMANT ADDRESS Records-U.S.P.H.S. Hospital, Baltimore, Md.		
18. 204.0 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			Septicemia		24 hours
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		Days
			Pneumonia, RLL		
			(C) Acute lymphocytic leukemia		2 Years
19. 204.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 7 19 68 to July 4 19 68 , that (XX) (we) last saw the deceased alive on July 4 19 68 and that in (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE Walter F. Oster M.D.				23B. DATE SIGNED July 4, 1968	
23C. PHYSICIAN'S NAME (Type) Walter F. Oster, M.D.				23D. ADDRESS U.S.P.H.S. Hospital, Baltimore, Md. 21211	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY Presbyterian Cemetery	
				24D. LOCATION (City, town, or county) (State) Gerrardstown West Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Finkbeiner		25C. FUNERAL DIRECTOR ADDRESS Howard K. Brown Brown Funeral Home-Martinsburg, W. Va. 25401	



BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILHILMINA A. MAIDEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> July 5, 1968 2:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 111 W. Center Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1968 2:45 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX female	7. RACE white	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Dec. 8, 1885 82		10. AGE (In years last birthday) 82		E. STREET AND NUMBER 111 W. Center Street, Apt. 509	
11. BIRTHPLACE (State or foreign country) Williamsburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ADOLPH ALSCHUL	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chr. Sc. practitioner		14B. KIND OF BUSINESS OR INDUSTRY Chr. Sc. Church		15. MOTHER'S MAIDEN NAME Mary Neuberger	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SECURITY NO. 212-36-6132		18. INFORMANT Mr. Chas. Maiden 111 W. Center St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/6/68 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7/6/68		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR R. E. Johnson	
25C. FUNERAL DIRECTOR Wm/ Cook-Brooks, Inc.		25D. ADDRESS 1217 St. Paul St/			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6944	
T-135 68- 6944		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED Hanna	
		2. DATE AND HOUR OF DEATH 7/5/68 12:20 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		A. STATE MARYLAND B. COUNTY BALTIMORE	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2618 Brendan Ave			
5. SEX M	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/9/10
9. AGE (In years last birthday) 57		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Communications Fireman-Balto. City Fire Dept	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSHUA TIPTON		14. MOTHER'S MAIDEN NAME ALICE STINEHCOMB	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-40-6004	
17. INFORMANT (nee Krein) above		ADDRESS WIFE ELIZ TIPTON	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease injury or complication which caused death.)		Carcinoma of Pancreas & Multiple Metastases and Intravascular Thrombosis	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBROVASCULAR THROMBOSIS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) PERIPHERAL VASCULAR OCCLUSION DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 7/3/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERIPHERAL VASCULAR OCCLUSION	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/30/68 to 7/5/68 , that (I) (we) last saw the deceased alive on 7/5/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE Martin E. Zipse, M.D.		23B. DATE SIGNED 7/5/68	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/68	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Zipse	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

James G.

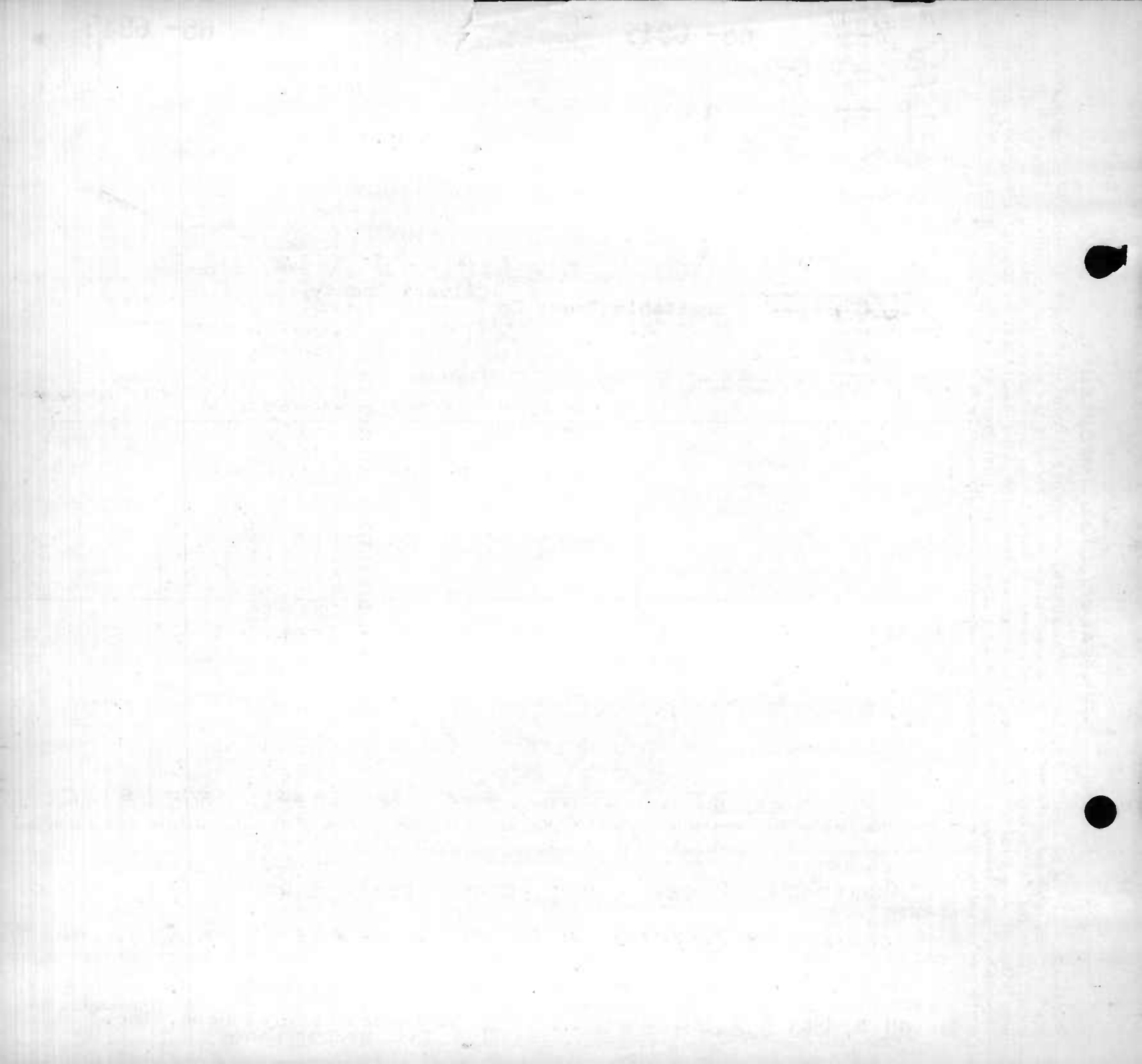
Commission of General & Military

Historians and Librarians

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-424 68-6945				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6945	
BIRTH NO.				1. NAME OF DECEASED Laverne			
(Type or Print) IRENE BLACKWELL				2. DATE AND HOUR OF DEATH JULY 4 1968 12:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL				A. STATE MARYLAND			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1532 LOCHWOOD RD.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-1-23		9. AGE (In years last birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10B. KIND OF BUSINESS OR INDUSTRY Equitable Trust Co		11. BIRTHPLACE (State or foreign country) Calvert County MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC HILL				14. MOTHER'S MAIDEN NAME GRACE BRYANT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217 10 2659		17. INFORMANT SAMUEL BLACKWELL		ADDRESS 1532 LOCHWOOD RD.	
18. 174X I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(B) CARCINOMA OF BREAST DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				_____			
170X II				CONGESTIVE HEART FAILURE			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				_____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 19 68 to JULY 4 19 68 , that (I) (we) lost saw the deceased alive on JULY 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corazon Z. Vergara, M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED July 4, 1968	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D. DEGREE				23D. ADDRESS Church Home & Hosp. Baltimore, MD 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME OF CEMETERY or CREMATORY Valley Dulaney Mem. Gardens		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6946	
BIRTH NO. B-452		68-6946 CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNIE LOUISE BLANCH			2. DATE AND HOUR OF DEATH July 3, 1968 5:30 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md., B. COUNTY 21205		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 727 N. Linwood Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 727 N. Linwood Ave.		
5. SEX female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/4/88	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 185-10-5155B		17. INFORMANT Mrs. Edythe Deegan, dght. above	
				ADDRESS	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC & HYPERTENSIVE HEART DISEASE.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetic Mellitus		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1963 to July 3, 1968 , that (I) (we) last saw the deceased alive on June 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Andrew Lemischka				23B. DATE SIGNED 7/3/68	
23C. PHYSICIAN'S NAME (Type) Dr. Andrew Lemischka				23D. ADDRESS 2608 E. Baltimore St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.	
				ADDRESS 2601 E. Madison St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6947	
BIRTH NO. H-534 68-6947				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HANDLEY, ALFORD KYNWOOD			2. DATE AND HOUR OF DEATH 7/7/68 6 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL 36			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1635 COVINGTON ST.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-8-97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ALFRED HANDLEY			14. MOTHER'S MAIDEN NAME GERGRUDE PURDY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-052-365	17. INFORMANT ADDRESS DR C.N. RAO F.S.H.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Heart Disease (B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma, rectosigmoid. 15-4X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 15-4X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 6/21/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED B.P.H. & Carcinoma Recto-Sigmoid Colon		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19/1968 to 7/7/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. C. Nageswara Rao			23B. DATE SIGNED 7-7-1968		23C. PHYSICIAN'S NAME (Type) DR C. NAGESWARA RAO MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-68		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
24D. LOCATION (City, town, or county) (State) Edmondson Ave. & Longwood St. Balto Md		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
25B. NAME OF REGISTRAR Robert E. Flynn		25C. FUNERAL DIRECTOR ADDRESS Flynn & Fleming, 1422 Light St., Balto. Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6948	
BIRTH NO. 68-04341		C-320 68-6948			
1. NAME OF DECEASED (Type at Print) Lisa S. Cates			2. DATE AND HOUR OF DEATH July 3, 1968 0:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. SEX F			6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Campbell		14. MOTHER'S MAIDEN NAME Joanne		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Grandmother	
18. 746.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart Failure Congenital heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 754.5 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6:00 PM, July 2, 1968 to 0:45, July 3, 1968 , that (I) (we) last saw the deceased alive on 0:45, July 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.					
23A. SIGNATURE Shih-Wen Huang MD.				23B. DATE SIGNED July 3, 1968	
23C. PHYSICIAN'S NAME (Type) SHIH-WEN HUANG		23D. ADDRESS Dept. of Pediatrics, Univ. of Md. Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
25A. NAME OF REGISTRAR Robert E. Farley		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR WM MARCH 928 E NORTH AVE	

University of Maryland

N F

Marshall

James

University

Threat Factor

Unpredictable threat factor

100.00%

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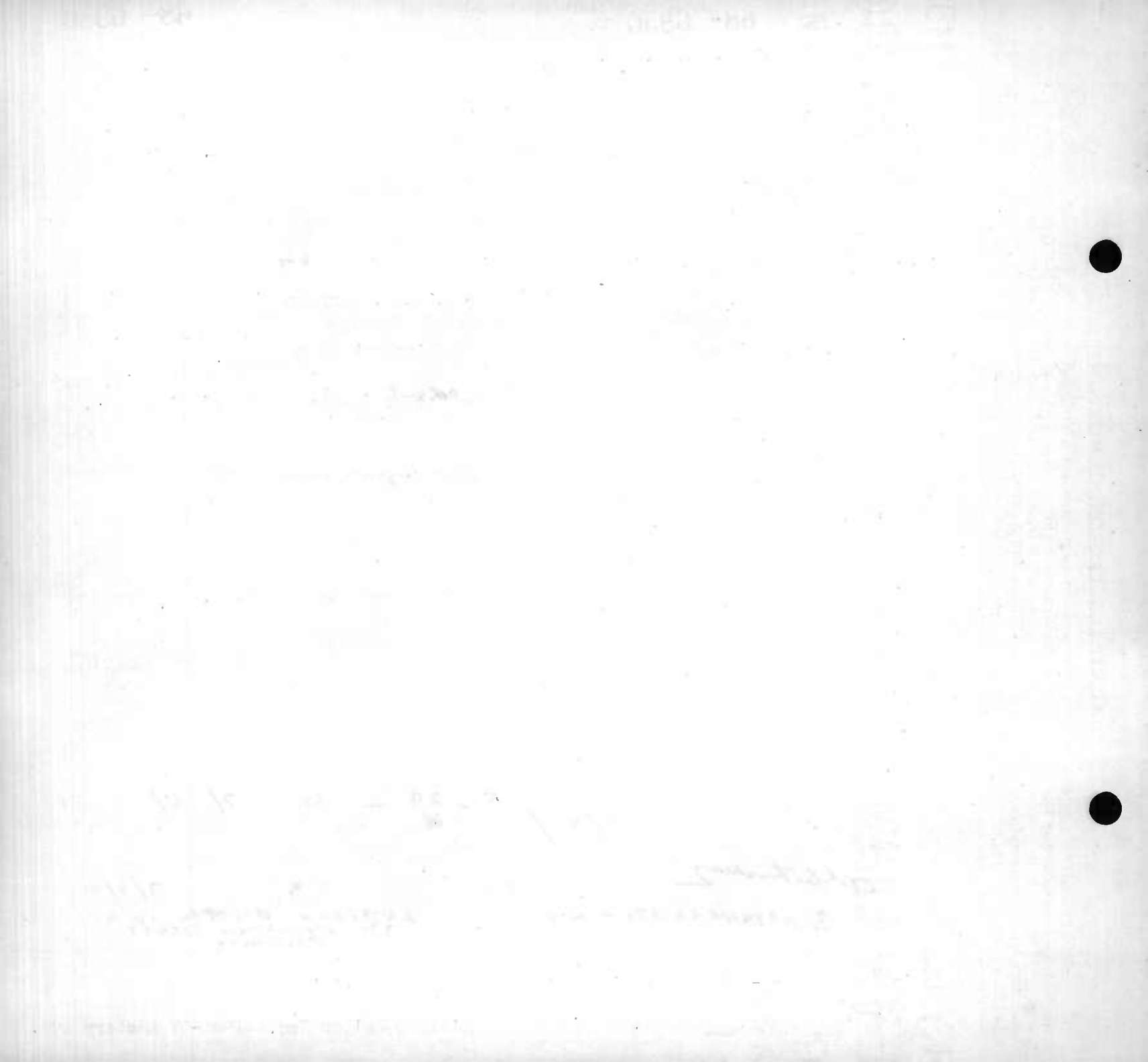
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BALTIMORE CITY HEALTH DEPARTMENT				68- 6949			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 68- 6949			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
SAMUEL H. HARDY		7 1 68				12:50 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month Day Year		Hour	
60 1122 N. Carey St. D.O.A.		July 1, 1968				12:50 p M.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Male		Colored				A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Nov 18, 1910		57		Maryland		Edward Hardy	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Laborer				Julia		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		19. CAUSE OF DEATH	
		Pauline Sturdivant		4231 Norfolk Av		Arteriosclerotic cardiovascular disease	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?		23.			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Edward F. Wilson</i> M.D.		DATE SIGNED		July 1, 1968			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
		Burial		7/5/68		Mt Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1968		Robert E. Taylor		Wm C March		928 E. North Ave.	

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or letter body with several paragraphs of text that is mostly illegible due to fading and bleed-through.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>68- 6950</u>	
<div style="display: flex; justify-content: space-between;"> C-560 68- 6950 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Ethel K. Connor</u>		2. DATE AND HOUR OF DEATH <u>7-6-68 at 4:15 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSPITAL 2 Maryland 730, Ashburton Street</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Female</u>			6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>1-15-04</u>		9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk Part-time</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Straub</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Dorn</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Marilyn Arellano</u> Address <u>Annapolis, Maryland 393 Hilltop Lane,</u>	
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>18. <u>162.1 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE <u>Bronchogenic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u></p> </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-29-1968</u> to <u>7/6/1968</u> , that (I) (we) last saw the deceased alive on <u>7/6/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>7/6/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. MATHIPRAKASAM M.D.</u>		23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND 730, ASHBURTON STREET BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-1968</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1968</u>			
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</u>			



68- 6951 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68- 6951

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) JOHN P. BANNON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 4, 1968 Hour 5:10 P. M. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 283 Mason Ct. (MASON)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 4, 1968 5:10 P. M. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
9. DATE OF BIRTH Jan 25 1906		10. AGE (In years last birthday) 62 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto Md		12. CITIZEN OF WHAT COUNTRY? Hugh Bannon	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na or unknown) (If yes, give war or dates of service) no no		17. SOCIAL SECURITY NO.	
18. INFORMANT Wm Bannon Balto Md		ADDRESS	
19. 149X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Pharynx (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
148X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-68	
24C. NAME of CEMETERY or CREMATORY New Cathedral Cem		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins		ADDRESS	

DATE SIGNED
July 5, 1968

VS 151-REV. 1/1/68

10-100

10-100

(10-100)

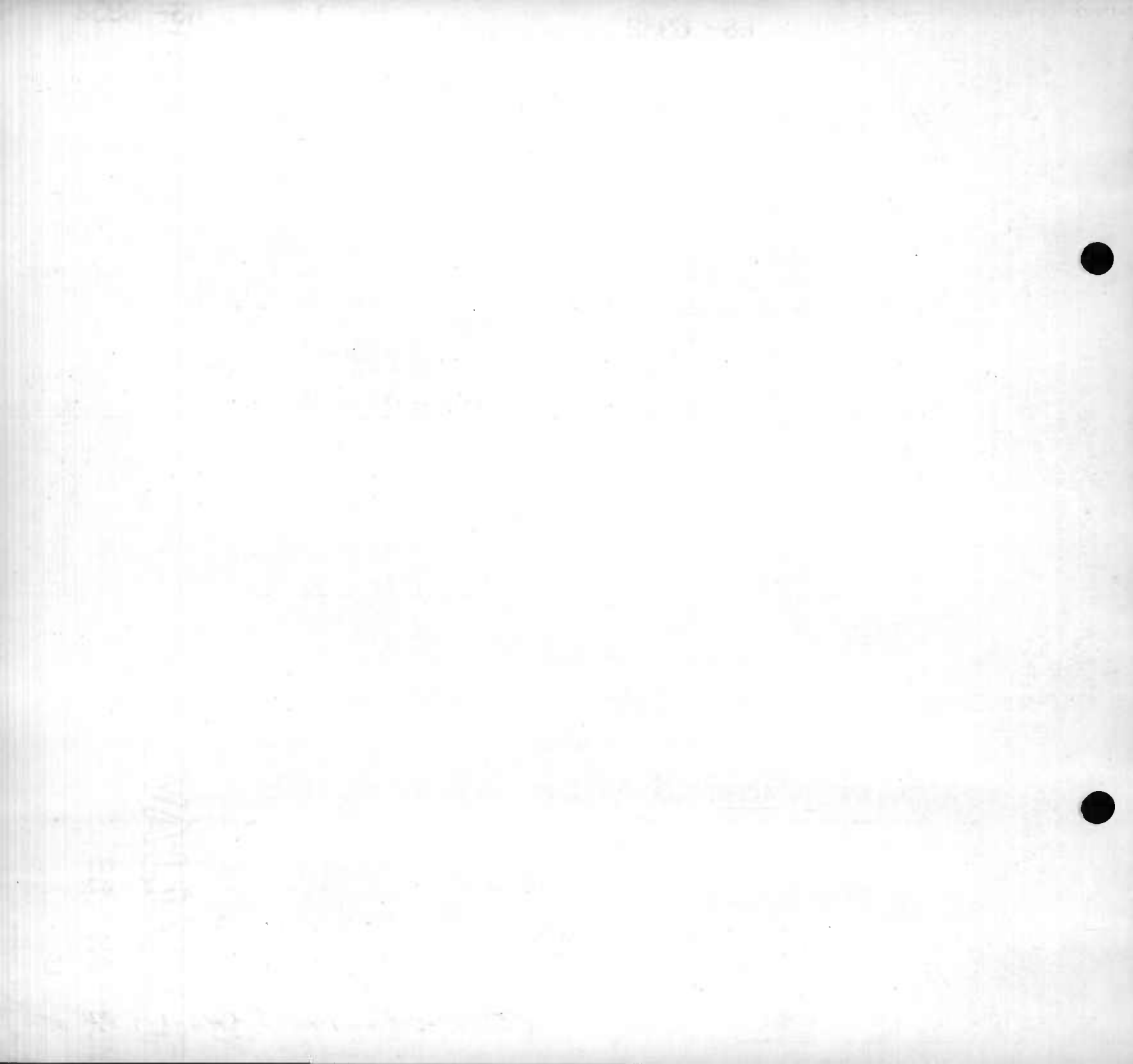
10-100

MAILED 10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
JENKINS, Miss HELEN				7-6-68 1-20 AM				HELEN MAY JENKINS			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				5. CITY OR TOWN				6. INSIDE CITY LIMITS?			
MARYLAND				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
7. STREET AND NUMBER				8. DATE OF BIRTH				9. AGE (in years last birthday)			
827 LINDEN AVE				FEB 7 1919				49			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
WRAPPER (Reese Press, Inc) Printing				BALTIMORE, MD				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
JOHN HERBERT JENKINS				EDNA ADELE AMERY				No			
16. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
215-24-6897				CHARLOTTE L. McCARROLL				Daughter			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				19. ANTECEDENT CAUSES				20. CAUSE OF DEATH			
410.9 I				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest			
								(B) AC Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:			
								(C) A-S-C-U-D			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				22. I certify that (I) (this hospital) attended the deceased from 7, 3, 19 68 to 7, 6, 19 68, that (I) (we) lost saw the deceased alive on 7, 5, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23. DATE SIGNED			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>							
23A. SIGNATURE				23B. ADDRESS				23C. DATE SIGNED			
Mohammad Sidig				827 Linden Ave Baltimore Md				7-6-68			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY OR CREMATORY			
Burial				July 9-68				Mt. Olivet Cemetery			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR			
JUL 8 1968				A. D. E. Evans				CURTIS E. EVANS			
								1400 S. CHARLES ST 30			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print) EDWARD F. SIDOR EDWARD F. SIDOR		2. DATE AND HOUR OF DEATH 7/7/68 4:30 A.M. 17-7-68 4:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 31 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 6731 BOSTON AVENUE - 21222					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-18	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician's Helper		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) BUFFALO, NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN SIDOR			
14. MOTHER'S MAIDEN NAME Anna Bak		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 215-05-7839		17. INFORMANT BALTIMORE CITY HOSPITALS RECORDS: 4940 EASTERN AVENUE #21224			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, MASSIVE DECVBITI		DUE TO, OR AS A CONSEQUENCE OF: > 4 mos			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 193.0 II GRADE II ASTROCYTOMA (frontoparietal glioma)		DUE TO, OR AS A CONSEQUENCE OF: > 8 years			
19A. DATE OF OPERATION 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GRADE II ASTROCYTOMA		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-9-1968 to 7-7-1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-7-1968 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Rosenbaum, M.D.				23B. DATE SIGNED 7-7-68	
23C. PHYSICIAN'S NAME (Type) DR. ROBERT ROSENBURM MD				23D. ADDRESS BALTIMORE, MARYLAND 21224 BALTIMORE CITY HOSPITALS 4940 EASTERN AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/68		24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968			
25B. NAME OF REGISTRAR Robert E. Jabara		25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231			

(Private Property of)

No

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **68- 6954**

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month		Day		Year		Hour	
		RICHARD DOBSON		7		4		68		2:50 p		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD		Month		Day		Year		Hour			
00 251 S. Loudon St. D.O.A.		July 4, 1968		2:50p		M.							
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
9. DATE OF BIRTH		10. AGE (In years last birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER							
10/8/68- 1911		55- 56				251 S. Loudon St.							
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME									
Maryland		U.S.A.		John Dobson									
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME									
Conductor		Penna. R.R.		Estella May Callender									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS							
No.		215-01-6487		Mr. Wm.A. Dobson, 2911 Oakcrest Ave, 21234									
19. E 953X I		CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE		Asphyxia in plastic bag									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:													
11 E 979X		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED										21. AUTOPSY? (Yes or No)	
2												YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?									
		Home		251 S. Loudon St.									
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?									
7 2-3 68 ? m.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Asphyxiated in plastic bag									
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		ASSOCIATE MEDICAL EXAMINER		DATE SIGNED			
Edward F. Wilson		Edward F. Wilson, M.D.				<input checked="" type="checkbox"/>		<input type="checkbox"/>		July 5, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)							
Burial		7/6/68		Lorraine		Baltimore, Md.							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS							
JUL 8 1968		Robert E. J. J. J.		Witzke, 4101 Edmondson Ave.		21229							

000-29-007

VALLEY PARK
VALLEY FORGE
VALLEY GREEN

03-0025

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6955				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6955	
1. NAME OF DECEASED (Type or Print) <u>Clem Williams</u>				2. DATE AND HOUR OF DEATH <u>7-4-68</u> <u>8:30</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u> <u>Lombard and Greene Sts.</u> <u>Baltimore, Maryland</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>15-01</u>	
C. CITY OR TOWN <u>Baltimore - 21217</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>1730 Carey Street</u>							
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-29-89</u>	9. AGE (In years, last birthday) <u>69</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Williams</u>				14. MOTHER'S MAIDEN NAME <u>Louise</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>216-10-0723</u>		17. INFORMANT <u>Bernidine Williams</u>		ADDRESS <u>1730 N. Carey St.</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial infarct</u> (B) <u>Atherosclerotic C.A.H. disease & myocard. ischaemia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Myocardial infarct.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>420.1 II</u> <u>pancytopenia</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>68</u> to <u>July 4</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 4</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James E. Gurdard M.D.</u>				23B. DATE SIGNED <u>July 4, 1968</u>			
23C. PHYSICIAN'S NAME (Type) <u>James E. Gurdard</u>				23D. ADDRESS <u>22 S. Greene Street.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-68</u>		24C. NAME of CEMETERY or CREMATORY <u>Ba. H. Nat. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Geo. J. Kelley</u>		ADDRESS <u>1348 N. Calhoun St.</u>	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6956				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6956	
1. NAME OF DECEASED (Type or Print) BELLARD, ALICE H.				2. DATE AND HOUR OF DEATH JULY 06, 1968 6:40 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILKENS AND CATON AVENUE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 21228 Balt. Co. 53-00 B. COUNTY			
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 01 13 95		9. AGE (In years lost birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				11. BIRTHPLACE (State or foreign country) East Orange NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BELLARD, WILLIAM W. Hazzard				14. MOTHER'S MAIDEN NAME Ottillie E. Dempker (METZLER) BELLARD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Carl J. Bellard 2315 Old Frederick Rd. ST AGNES HSP WILKENS & CATON AVENUE	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JUNE 26, 19 68 to JULY 06, 19 68 , that (X) (we) last saw the deceased alive on JULY 06, 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. Wong				23B. DATE SIGNED 07-06-68			
23C. PHYSICIAN'S NAME (Type) Lee Man Wong M.D.				23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 7-8-68		24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Edwards		25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Av			

Acute myocardial infarction
Coronary artery

MD

166 Main Street

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6957	
M. 320 68-6957				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MAGGIE HUGHES MATTHEWS		2. DATE AND HOUR OF DEATH 7-5-68 1:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 5-01			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE MD 21205		C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-11-97	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?		9. AGE (In years lost birthday) 70	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) BALTO. MD	
				12. CITIZEN OF WHAT COUNTRY?	
17. INFORMANT Edward Holmes		ADDRESS 1245 Orleans St			
18. 25-1X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CNS damage		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CNS damage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4+ days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. uremia / Hypoglycemia		(B) DUE TO, OR AS A CONSEQUENCE OF: uremia / Hypoglycemia		(C) Indeterminate	
270X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7/1/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (I) (this hospital) attended the deceased from 7/1/68 to 7/5 19 68 , that (I) (we) last saw the deceased alive on 7/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David L. Jackson		23B. DATE SIGNED 7/5/68		23C. PHYSICIAN'S NAME (Type) David L. Jackson M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/68		24C. NAME OF CEMETERY or CREMATORY MT. Calvary	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Joseph J. Locke	
				ADDRESS 1304 N. Central Ave	

DATE: 11-11-11
TIME: 11:11
X

YES NO

David Johnson

THE JOURNAL OF THE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 68-6958	
D-200		68-6958		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Raymond T Dix Sr.</i>		2. DATE AND HOUR OF DEATH <i>7-6-68</i> <i>8 30</i> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>1043 LERREW WAY</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-23-1918</i>	9. AGE (In years last birthday) <i>50</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHIPPING CLERK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DISTILLERY</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>GEORGE W. DIX</i>		14. MOTHER'S MAIDEN NAME <i>MYTRIE A. MURRAY</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes. W-W-II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Anna Plover Dix</i>	
18. <i>153.2.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Acute Peritonitis & probable sepsis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>status post op 4 days segmental resection of desc. colon</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of descending colon</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 days</i> <i>?</i>	
153.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Pulmonary Emphysema.</i>			
19A. DATE OF OPERATION <i>3/2/68</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca colon</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from <i>15 June 1968</i> to <i>6 July 1968</i> , that (H) (we) last saw the deceased alive on <i>6 July 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>J. S. Oldroyd M.D.</i>		23B. DATE SIGNED <i>7/6/68</i>		23C. PHYSICIAN'S NAME (Type) <i>J. S. Oldroyd M.D.</i>	
23D. ADDRESS <i>Mercy Hosp Balto, Md</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-10-68</i>	
24C. NAME OF CEMETERY or CREMATORY <i>BALTO. NATIONAL CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO., Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1968</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>James Miller</i>		25D. ADDRESS <i>2534 Jefferson St.</i>	

2-23-1918 to
March 10, 1918

James Lee Duncan
P. O. Box
No. 100

March 10, 1918
P. O. Box 100

Dear Mr. Duncan:

I have just received your letter of the 23rd inst. and am glad to hear from you.

I am sorry that I cannot give you a more definite answer at this time.

I will try to get the matter straightened out as soon as possible.

Very truly yours,
J. L. Duncan

Yours very truly,
J. L. Duncan

Enclosed find \$10.00

for the same.

Very truly yours,
J. L. Duncan

Enclosed find \$10.00

1

11-625 68-6959 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6959

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHNSON K. MORRISON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 5 68 7:10 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1968 7:10 a. M.	
6. SEX Male		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH July 17, 1905		10. AGE (In years last birthday) 62 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-01-4458	
18. INFORMANT Elizabeth M Morrison		ADDRESS Same	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 422.1 II		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. DATE SIGNED July 5, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/68	
24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Tabor	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc		ADDRESS Baltimore, Maryland	

VS 151-REV. 1/1/68

65-6353

65-6353



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-552 68-6960				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6960	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				(Stone) Mitchell Andre' Kaminski		July 5, 1968 1:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.		B. COUNTY	
Church Home and Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 202 S. Wolfe Street			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1908	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Interior Decorator		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME Stanislaws Kaminski				14. MOTHER'S MAIDEN NAME Amna ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-1779		17. INFORMANT Mrs Romaine S Kaminski		ADDRESS Same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
19. 420.1 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1967 to 1-29-68, that (I) last saw the deceased alive on Jan 29-68 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE MARION FREEMAN, M.D.				23B. DATE SIGNED 7-5-68			
23C. PHYSICIAN'S NAME (Type) MARION FREEMAN, M.D.				23D. ADDRESS 5211 HARFORD RD BALTO MD 21214			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/68		24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.			

1

F-632 68- 6961 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 68- 6961

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **LAWRENCE H. FOERTSCH Jr**

2. DATE OF DEATH Known ☒ Estimated ☐ Month **7** Day **7** Year **68** Hour **5:25** p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE PRONOUNCED DEAD Month **July** Day **7** Year **1968** Hour **5:25** p. M.

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Baltimore City Hospital D.O.A.**

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY **Balto.**

6. SEX **Male** 7. RACE **White** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH **Jan 9, 1944** 10. AGE (In years lost birthday) **24** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.** 13. FATHER'S NAME **Lawrence H. Foertsch Sr**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Machinist** 14B. KIND OF BUSINESS OR INDUSTRY **Beth. Steel Co** 15. MOTHER'S MAIDEN NAME **L. Margaret Hecker**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes 3/13/61 - 2-28-67** 17. SOCIAL SECURITY NO. **212-40-0783** 18. INFORMANT **Sharon F Foertsch** ADDRESS **Same**

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **7/11/68** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED **Water** 21. AUTOPSY? (Yes or No) **Yes**

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **Water** 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **150 ft. from Ramoana Beach, Millers Island** 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Subject jumped into water and drowned**

22D. TIME OF INJURY (APPROX.) **7 7 68 4:39p** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Edward F. Wilson, M.D.** M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **July 8, 1968**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7/11/68** 24C. NAME OF CEMETERY or CREMATORY **Baltimore National** 24D. LOCATION (City, town, or county) (State) **Baltimore, Maryland**

25A. DATE REC'D BY HEALTH DEPT. **JUL 8 1968** 25B. NAME OF REGISTRAR **Robert E. Taylor, Jr.** 25C. FUNERAL DIRECTOR ADDRESS **Leonard J Ruck Inc Baltimore, Md.**



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-420		68- 6962		BALTIMORE CITY HEALTH DEPARTMENT		68- 6962	
BIRTH NO.		CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		SCHULZ, CHARLES H., Sr.				2. DATE AND HOUR OF DEATH 2h 40' pm. July 6, 1968. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.		A. STATE Md.				B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				27-34	
		D. STREET ADDRESS (If rural, give location) 5607 BELLE VISTA AV. BALTO MD.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 11/20/1894	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--- Bendix Corp.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oswald H. Schulz		14. MOTHER'S MAIDEN NAME Margaret E. Shew					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-5185		17. INFORMANT Mrs. Beatha A. Schulz		ADDRESS (Same)	
18. 441.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) CARDIAC ARREST - SHOCK DUE TO (B) HEMORRAGY, ACUTE DUE TO (C) RUPTURE AORT. ANEURISM				INTERVAL BETWEEN ONSET AND DEATH 6' 2h 40' 2h 40'	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 451X II							
19A. DATE OF OPERATION 17/6/68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED STOP HEMORRAGY		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11 h. 7/6/68 1968 to 2h 40' 7/6/1968, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Carlos A. Le Plaza		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 7/6/68	
23C. PHYSICIAN'S NAME (Type) CARLOS A. LEA PLAZA		23D. ADDRESS 110 W 39 ST. BALTO MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/68.		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Faldy		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

7/18
UNION MEMORIAL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

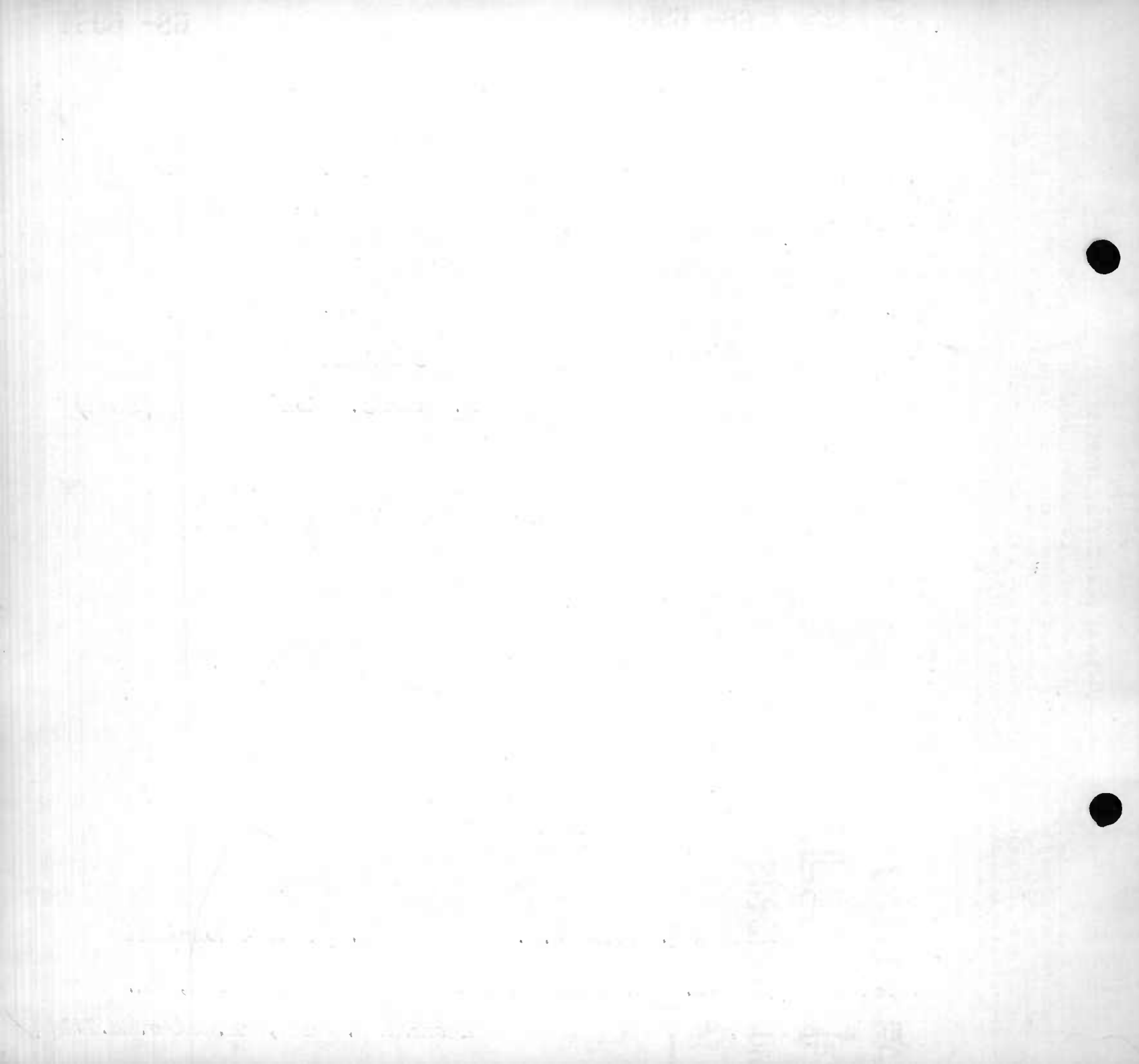
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68-6963
<div style="display: flex; justify-content: space-between;"> H-310 68-6963 CERTIFICATE OF DEATH </div>					
BIRTH NO. Samuel Barton Hatoff		1. NAME OF DECEASED Type or Print SAMUEL BARTON HATOFF		2. DATE AND HOUR OF DEATH 7-7-68 5:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 10, 1890 78		9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WINDOW DRESSER			11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL HATOFF			14. MOTHER'S MAIDEN NAME ROSE APELPOD		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 053-03-4482 A		17. INFORMANT Robert Hatoff 5106 Pembroke Ave. 6
18. 577.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PANCREATITIS ACUTE HEMORRHAGIC		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
<div style="display: flex; justify-content: space-between;"> 587.0 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). </div>					
19A. DATE OF OPERATION 7-6-68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TUBERCLE OUT PERFORMED UNDER		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-6-68 19 to 7-7-68 19, that (I) (we) last saw the deceased alive on 7-7-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo N. Tuxson			23B. DATE SIGNED 7-7-68		23C. PHYSICIAN'S NAME (Type) Ricardo N. Tuxson M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/68		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION Dorsey, Md.		24E. NAME of REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	

Richard M. Lusk
Richard M. Lusk

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

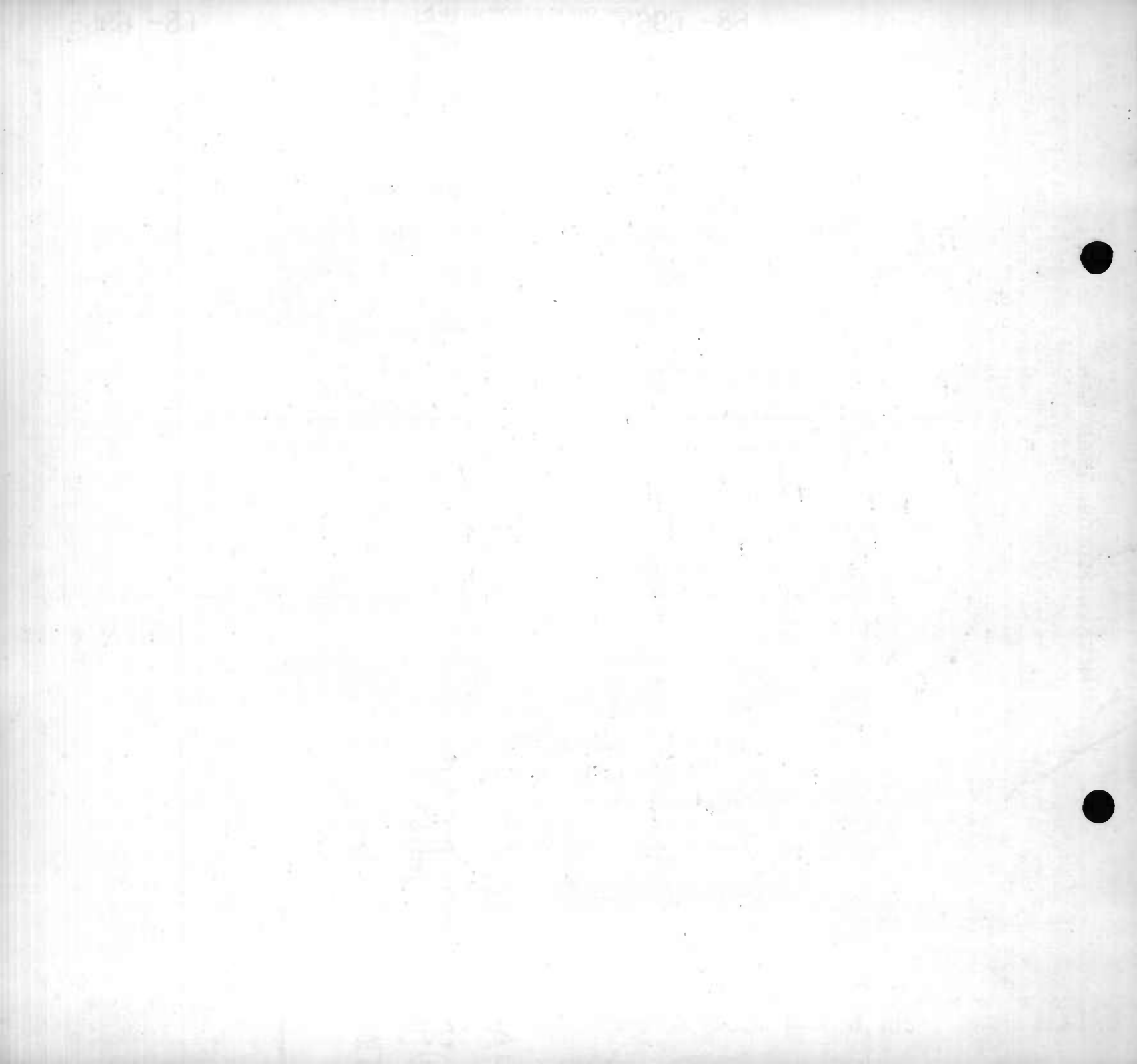
B-420 68-6964 BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6964	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Block, Florence B.				2. DATE AND HOUR OF DEATH July 7, 1968 6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4302 Woodlea Ave.	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08/26/1906	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael T. Mahon				14. MOTHER'S (MAIDEN) NAME Florence Fink	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John F. Block	
				ADDRESS (Same)	
18. 391.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pericardial Effusion/atrial stenosis Valvular Disease (tricuspid insufficiency) (B) DUE TO, OR AS A CONSEQUENCE OF: Rheumatic Fever (C) 3 years 34 years				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 401.3 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from July 2 19 68 to July 7 19 68 , that (I) <u>(we)</u> last saw the deceased alive on July 7 19 68 and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Richard C. Keech M.D.				23B. DATE SIGNED July 7, 1968	
23C. PHYSICIAN'S NAME (Type) Richard C. Keech M.D.				23D. ADDRESS Md. General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/68		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Fabela		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6965	
T-512 68- 6965 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Betty J. Thompson		7-5-68 3:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			A. STATE B. COUNTY Baltimore Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 608 N. Carey St.		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-41	9. AGE (In years lost birthday) 27	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Sidney Rhue		14. MOTHER'S MAIDEN NAME Minnie Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-48-2631		17. INFORMANT Minnie Brown	
18. 396.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) SUSPECTED PULMONARY EMBOLI (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: THROMBOPHLEBITIS (B) Calf (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days 5-7 days		19. 410X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). RHEUMATIC HEART DISEASE = AORTIC and Mitral valve disease 6 years			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/2 1968 to 7/5 1968, that (I) (we) last saw the deceased alive on 7/5 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronica M. Kluge, M.D.				23B. DATE SIGNED 7/5/68	
23C. PHYSICIAN'S NAME (Type) RONICA M. KLUGE, M.D.				23D. ADDRESS Univ. Hospital, Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/68		24C. NAME OF CEMETERY, or CREMATORY Mt Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		24E. FUNERAL DIRECTOR Walter L. Cunningham		24F. ADDRESS 2302 N. Hollins Ave. Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Walter L. Cunningham	



52-01-53 1B

W-300 68- 6966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

68- 6966

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM E. WHITE

2. DATE AND HOUR OF DEATH

7:45 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3 Baltimore City Hospital
4940 EASTERN AVE., BALTO., MD. #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2108 Mt. Holley St #21224 007

5. SEX

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

B. DATE OF BIRTH

9. AGE (In years
last birthday)

Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Walter S. Smithwick

RECORDS: BALTO. CITY HOSPITALS
4940 EASTERN AVE., BALTO., MD.

467.2 II

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-25 19 68 to 7-5 19 68,
that (I) (we) last saw the deceased alive on 7-5-19 68 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

DEGREE

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7-5-68

23C. PHYSICIAN'S
NAME (Type)

Walter S. Smithwick MD

23D. ADDRESS

4940 EASTERN AVE., BALTO., MD. 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

1 State

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JUL 8 1968

Robert E. Taylor

Morton S. Dyett F.H. 1701 LAURENS

VS 150-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1945

1946

1947 1948 1949 1950

1951 1952 1953

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1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025

BIRTH NO.		1. NAME OF DECEASED (Type or Print) DAVID WILSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> July 5, 1968 Hour 7:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1968 7:00 P.M.	
6. SEX male		7. RACE negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 1-13-1931		10. AGE (In years last birthday) 37		11. BIRTHPLACE (State or foreign country) Monesson, Pennsylvania	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Henry Wilson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housing Authority	
15. MOTHER'S MAIDEN NAME Aslean Gordon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-26-8843	
18. INFORMANT Mrs. Aslean Wilson		ADDRESS 3704 Park Hots Ave		19. CAUSE OF DEATH Shotgun Wound of Neck	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
23. DATE OF OPERATION 7/5/68		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) Yes	
26. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIB-UTING CAUSE OF DEATH.		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) in front of 806 Summerset Street	
29. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7/5/68 6:35 P.		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		31. HOW DID INJURY OCCUR? subj. was shot in neck	
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/6/68</p> <p>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p>					
32. BURIAL CREMATION, REMOVAL (Specify) Burial		33. DATE 7-10-68		34. NAME of CEMETERY or CREMATORY Mount Auburn Cem.	
35. LOCATION (City, town, or county) (State) Baltimore, Maryland		36. DATE REC'D BY HEALTH DEPT. JUL 8 1968		37. NAME OF REGISTRAR Robert E. Feltz	
38. FUNERAL DIRECTOR MORTON & DYETT F.H.		39. ADDRESS 1701 Laurens St.			

WALTER H. WOOD

CONFIDENTIAL

I-220 68-6968

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6968

BIRTH NO.

1. NAME OF DECEASED

(CHARLES) CHARLIE N. ISSAC

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

Estimated ☐

July 5, 1968

9:40 A. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)
OR INSTITUTION

00 1615 W. Mulberry Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July 5, 1968

9:40 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

March 4 1902

10. AGE (In years
last birthday) 66If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1615 W. Mulberry Street

11. BIRTHPLACE (State or foreign country)

Summerton, S. C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Isaac

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Rail Road

15. MOTHER'S MAIDEN NAME

Lutina Nelson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

249-34-3508

18. INFORMANT

ADDRESS

Maggie Ragin 8109 Longfellow Ave. Bronx, N.Y.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic Cardiovascular Disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

422.1

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 5, 1968

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-9-68

24C. NAME of CEMETERY or CREMATORY

Wilson Chapel Chapel

24D. LOCATION

(City, town, or county)

(State)

Summerton, S.C.

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1968

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

ADDRESS

Morton & Dyett Funeral Home

08-08

08-08

X



WILLY BOHRS

WILLY BOHRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6969
7-236		68-6969		CERTIFICATE OF DEATH
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) Arleaver Foster			2. DATE AND HOUR OF DEATH 7/5/68 11 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital			C. CITY OR TOWN BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 902 Russell St.	
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/06	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) USA	
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irving Johnson			14. MOTHER'S MAIDEN NAME Amelia Gaither	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-10-6346-D	
			17. INFORMANT ADDRESS	
18. 433.1 II CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARRHYTHMIA				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(B) DUE TO, OR AS A CONSEQUENCE OF:				
(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (1) (this hospital) attended the deceased from 5/15 19 68 to 7/5 19 68 , that (1) (we) lost saw the deceased alive on 7/5 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Gary M. Lattin M.D.			23B. DATE SIGNED 7/5/68	
23C. PHYSICIAN'S NAME (Type) GARY M. LATTIN M.D.			23D. ADDRESS University Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-68		24C. NAME OF CEMETERY or CREMATORY Carver Memorial
				24D. LOCATION (City, town, or county) (State) Courville, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR ADDRESS CHARLES PRICE 661 W. Bane St.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6970

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IRVING E. MAXWELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 22, 1968 11:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 22, 1968 11:55 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH June 9, 1917		10. AGE (In years last birthday) 51 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John E. Maxwell		14. STREET AND NUMBER 5103 Fait Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Ruberta Adams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-05-9188		18. INFORMANT (Sister) ADDRESS Balto. Md. Mrs. Bernice Szczesniak, 424 S. Robinson St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E814.1 Injuries		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E812.4		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Eastern Avenue East of Macon Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) June 21, 1968 4:40P.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Edward F. Wilson M.D. EXAMINER'S NAME (Type) Edward F. Wilson, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 23, 1968			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/68	
24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR John J. Duda, 2829 Hudson St. Balto. Md.		ADDRESS	

WALL TO WALL

Handwritten signature and date: 1/11/12

R-526

68-6971

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-6971

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FLOYD ORVILLE RINKER

2. DATE
OF
DEATHKnown ☐ Estimated ☒

Month

Day

Year

Hour

June 23, 1968

11:00 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bank and Gusryan Sts.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

June 23, 1968

11:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Edgemere

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

7614 North Point Road

6. SEX

male

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

May 19, 1910

10. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF

WHAT COUNTRY?
U. S. A.

13. FATHER'S NAME

Tyler Rinker

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

14B. KIND OF BUSINESS OR INDUSTRY

Construction Co.

15. MOTHER'S MAIDEN NAME

Myra Moreland

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)
No

17. SOCIAL SECURITY NO.

215-03-1317

18. INFORMANT (Wife) Edgemere, ADDRESS Md. 21219

Mrs. Florence Rinker, 7614 North Point Rd.

19.

571-8

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Fatty Alteration of Liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

581.0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes (Partial)

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/24/68

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

6/26/68

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Memorial Park

24D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1968

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

Letter to Mr. [illegible]

Dear Mr. [illegible]:

I am writing to you

to inform you of the

results of the

WALLACE BOOTH

1-69-80

1-69-80

Very truly yours,

[illegible signature]

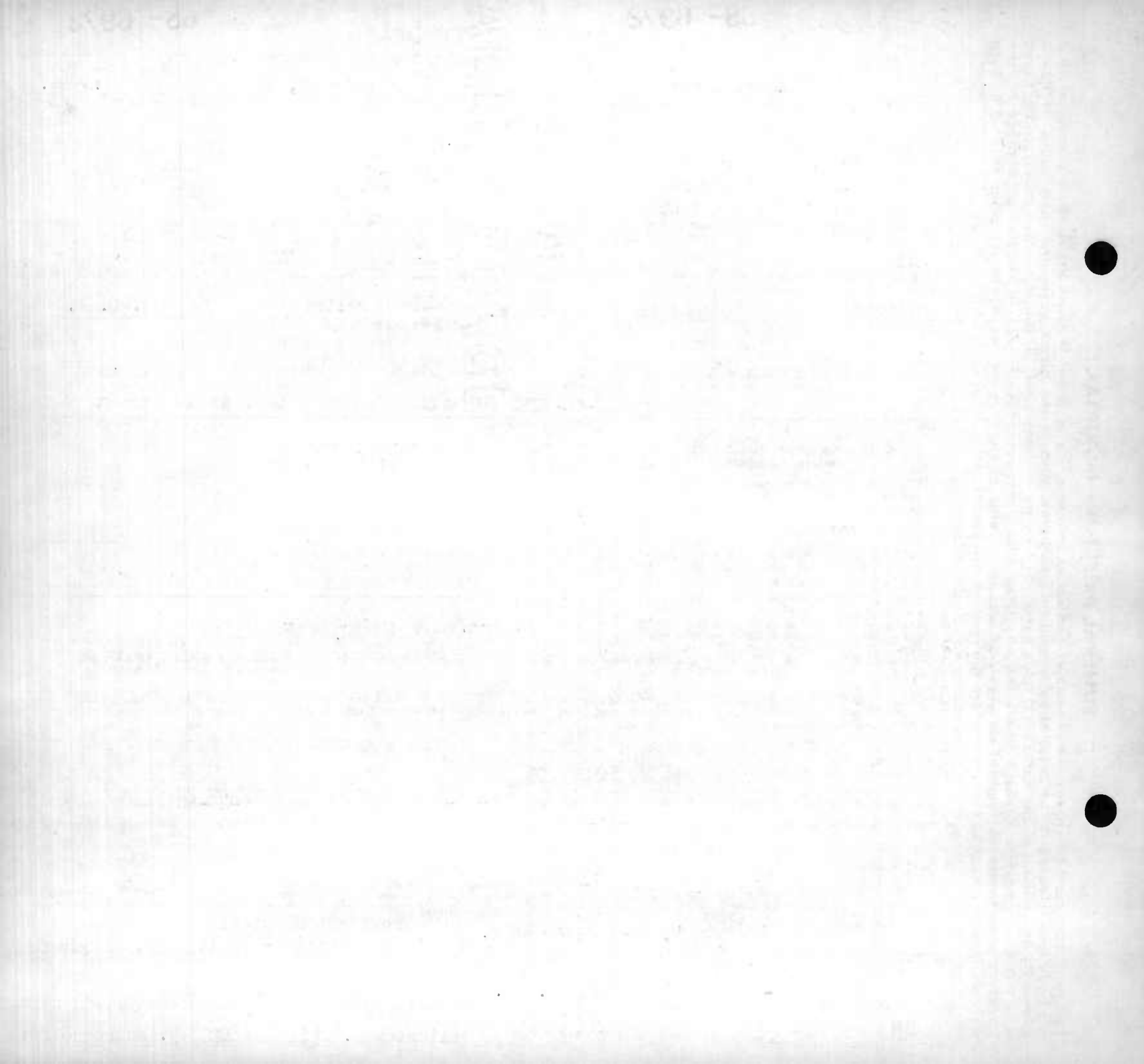
Very truly yours,

[illegible signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-260 68- 6972				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6972	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Fisher, Isom		June 29, 1968 10:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE B. COUNTY		5. AGE (In years lost birthday) 6. DATE OF BIRTH	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital 1514 Division Street Baltimore, Maryland				Maryland C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		74 7-14-94	
E. STREET AND NUMBER 1800 Mosher Street				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (In years lost birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Male				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Gas and Electric Co.	
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Isom Fisher	
14. MOTHER'S MAIDEN NAME Judy Plterson				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-3292	
17. INFORMANT ADDRESS Carrie Fisher 1800 Mosher Street				18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED II		20A. AUTOPSY? (Yes or No) Malnutrition, dehydration	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-24-68 to 6-29-68, that (I) (we) last saw the deceased alive on 6-29-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE Humberto V. Certera M.D.		23B. DATE SIGNED 7-1-68	
23C. PHYSICIAN'S NAME (Type) Humberto V. Certera M.D.				23D. ADDRESS Provident Hospital 1514 Division Street - Baltimore, Maryland		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7-2-68				24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968				25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-620		68-6973		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6973	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Beverly Jacqueline Dorsey				2. DATE AND HOUR OF DEATH June 28, 1968 11:47 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4216 Penhurst Avenue				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4216 Penhurst Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/32	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleanin g			10B. KIND OF BUSINESS OR INDUSTRY Dry Cleaning		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Preston				14. MOTHER'S MAIDEN NAME Martha Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-28-7829		17. INFORMANT ADDRESS Mrs. Barbara Satchell 2404 Keyworth Avenue			
18. 734.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Schroduma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 710.0 II				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1 19 67 to Oct 19 67 , that (I) (we) last saw the deceased alive on Sept 12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roland T. Smoot				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/1/68	
23C. PHYSICIAN'S NAME (Type) Roland T. Smoot				23D. ADDRESS 3817 Copley Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/68		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Fairbanks		25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe St	

*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-340		68-6974		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		68-6974				
BIRTH NO.					1							
1. NAME OF DECEASED (Type or Print) GEORGE R. WHITLEY					2. DATE AND HOUR OF DEATH June 28 1968 10:15 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND					A. STATE MD		B. COUNTY					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
					E. STREET AND NUMBER 3012 BRIGHTON STREET							
5. SEX M		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-4-22		9. AGE (In years lost birthday) 45		II Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II					16. SOCIAL SECURITY NO. 232-30-4310		17. INFORMANT Whitley CHART		ADDRESS 2723 Woodland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 330X II					19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Subarachnoid Hemorrhage (B) Rupture Berry Aneurysm (C) Hypertension?					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).												
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?								
22. I certify that (I) (this hospital) attended the deceased from 3:00 PM 6-28-1968 to 10:15 PM 6-28-1968 , that (I) (we) last saw the deceased alive on 6-28-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE S. Aziz					23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) S. AZIZ M.D.					23D. ADDRESS 730 Ashburton St. Baltimore MD 21210							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)						
Burial 7-5-68 Baltimore National		7-5-68		Baltimore National		Baltimore MD.						
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR William J. Phillips		25D. ADDRESS 1727 N. Mount						



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>G-450 68- 6975</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 68- 6975</p>			
1. NAME OF DECEASED (Type or Print) GILLIAM, John Henry		2. DATE AND HOUR OF DEATH 9:30am 7-4-68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION BALN Baltimore City Hospital		A. STATE Md B. COUNTY Balto.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Avenue, Baltimore, Maryland		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> 7:05	
5. SEX M		6. RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-11	
9. AGE (In years lost birthday) 56		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Gilliam		14. MOTHER'S MAIDEN NAME Ellen Miller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-09-1036	
17. INFORMANT Records: BCH-4940 Eastern Avenue 21224		ADDRESS	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung (metastatic)		2 1/2 yrs	
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) — (C) —			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 163X II			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 5/31/68 19 to 7/4/68 19 that (I) (we) last saw the deceased alive on 7/4/68 at 8:45am and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Christopher Stucky MD		23B. DATE SIGNED 7-4-68	
23C. PHYSICIAN'S NAME (Type) R. Christopher Stucky		23D. ADDRESS 4040 Eastern Ave. Baltimore Md. Apt 6128 Prof. Staff Apts East Pratt	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-68	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Randolph J. Collick		ADDRESS 2431 E. Oliver St.	

Bin (left) 11-4-11
M Negro

James C. Miller
Lester

213-04-1031

11-4-11
Mr. Miller

(~~unintelligible~~)
Germans of the last 2 years

no

2/11/08
2/11/08

R. Chamberlain
R. Chamberlain

4/1/08

2-4-07

4/1/08
4/1/08

1

5-315 68-6976 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68-6976

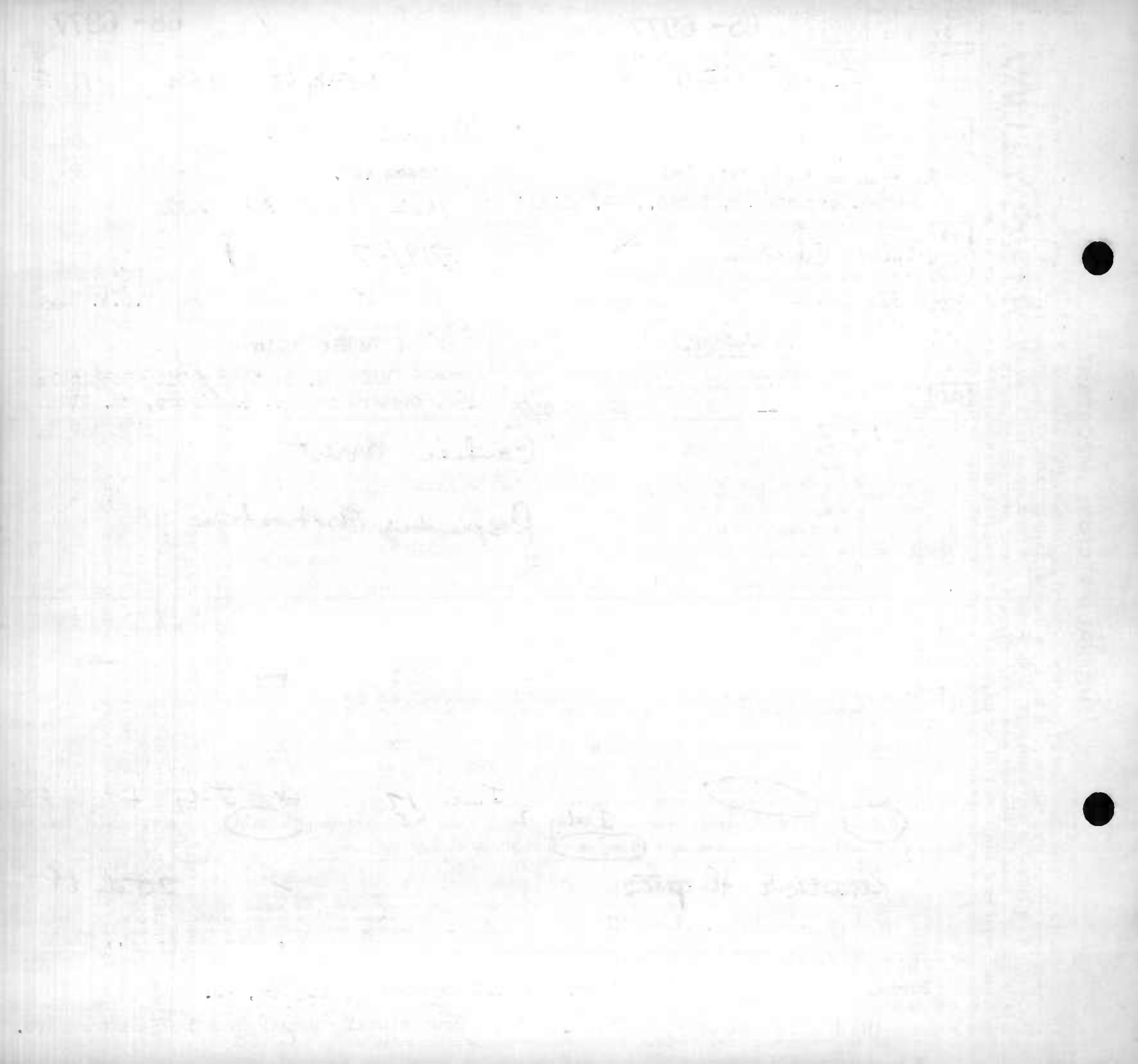
BIRTH NO. 01-24951 REG. NO. _____

1. NAME OF DECEASED (Type or Print) R. JACQUELINE STEVENSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>7</u> Day <u>1</u> Year <u>68</u> Hour <u>9:00 a.m.</u>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>31 City Hospital</u>		3. DATE PRONOUNCED DEAD Month <u>July</u> Day <u>1</u> Year <u>1968</u> Hour <u>9:00a m.</u>	
6. SEX <u>Female</u>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
7. RACE <u>Colored</u>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>8-26-1961</u>	10. AGE (In years lost birthday) <u>6</u>	E. STREET AND NUMBER <u>2717 E. Biddle St.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>John E. Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Patsy Watkins</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		14B. KIND OF BUSINESS OR INDUSTRY _____	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>NONE</u>	
18. INFORMANT <u>Mrs Patsy Stevenson</u>		ADDRESS <u>2717 E. Biddle St.</u>	
19. <u>E 8/15/1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Injuries</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <u>No</u>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Road</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>North Point Blvd. & North Blvd. Essex</u>	
22D. TIME OF INJURY (APPROX.) <u>6 24 68 10:07</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <u>Passenger in truck-fixed object coll.</u>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Edward F. Wilson</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward F. Wilson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>7-4-68</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Nazareth Church Crm. Winnsboro, S.C.</u>		24D. LOCATION (City, town, or county) (State) _____	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Randolph J. Collick</u>		ADDRESS <u>2431 E. Oliver St.</u>	

VS 151-REV. 1/1/68

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-423 68-6977		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6977	
BIRTH NO. EDITH FAITH PELLICOTT		2. DATE AND HOUR OF DEATH 2 July 68 11 AM 11 A M.			
1. NAME OF DECEASED (Type or Print) Faith Pellicott		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue, Balto., Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE		53-00	
C. CITY OR TOWN Essex (210)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 1602 Gail Rd., 21222	
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/27	9. AGE (In years lost birthday) 41	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assemble Worker		10B. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ellswick		14. MOTHER'S MAIDEN NAME HELEN Mc Glouthlin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 228 16 0163		17. INFORMANT RECORDS: Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224	
18. 519.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac arrest		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Obstruction			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: B			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
527.2 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from June 17 19 68 to July 2 19 68, that (I) (we) last saw the deceased alive on July 2 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Kenneth E. Fligsten		23B. DATE SIGNED 2 July 68		23C. PHYSICIAN'S NAME (Type) KENNETH E. FLIGSTEN	
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MD., 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68	
24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery, Baltimore, Md.		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	
25B. NAME OF REGISTRAR Robert E. Sadowski		25C. GENERAL DIRECTOR Brzezinski		25D. ADDRESS funeral home 1407 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

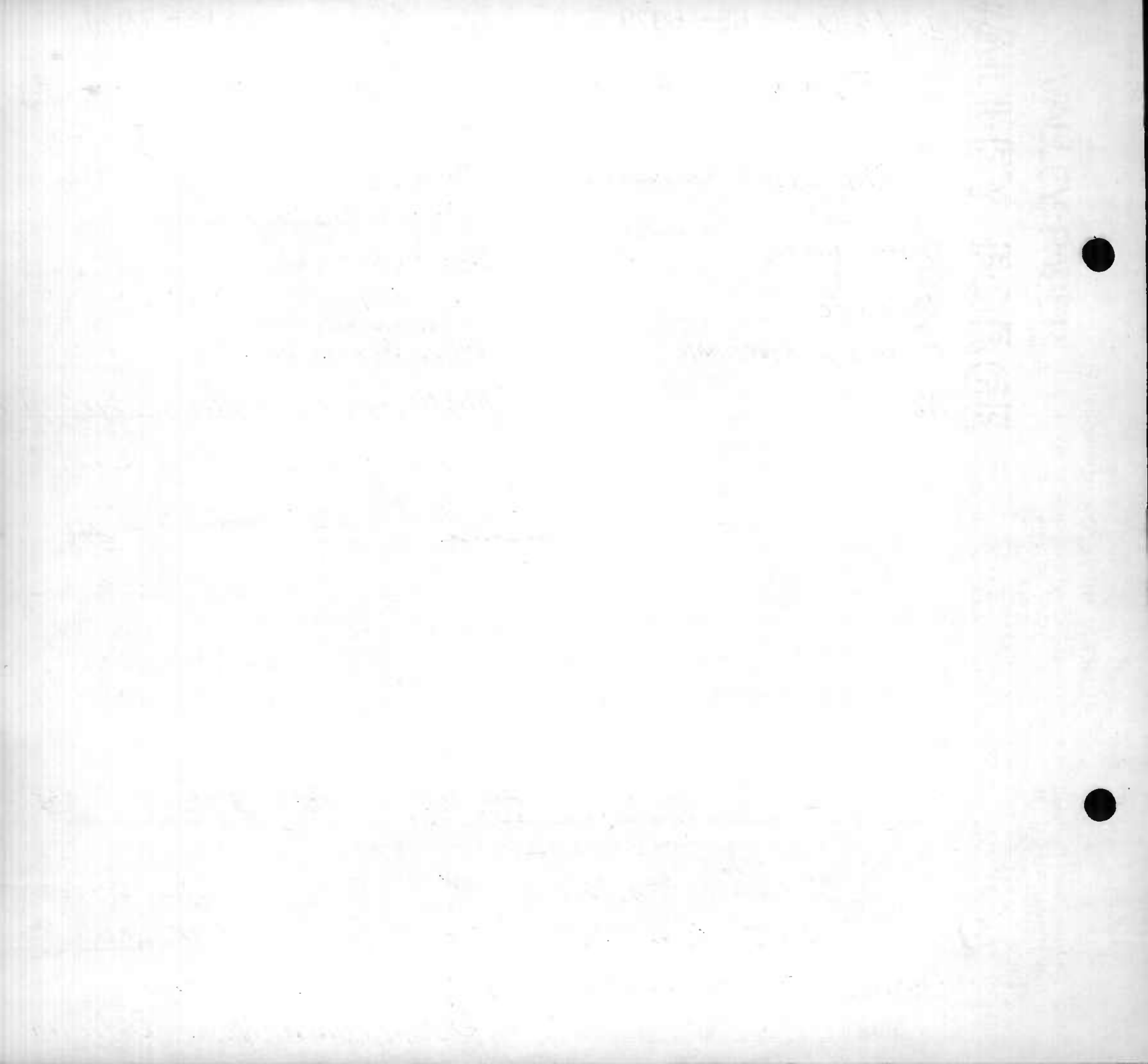
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6978	
BIRTH NO. 5-342				68-6978	
1. NAME OF DECEASED (Type or Print) MATILDA STILES			2. DATE AND HOUR OF DEATH July 1, 1968 11:15 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium 6116 Belair Road			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Middle River 20 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 381 Endsleigh Ave.		
5. SEX Female	6. RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1886	9. AGE (In years last birthday) 81	If Under 1 Yr. Months; Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) North Dakota	
13. FATHER'S NAME T. Olson			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 501 07 2996D		17. INFORMANT Robert Stiles
			ADDRESS Same		
18. 412.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident Sudden ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardio Vascular disease 2 yrs (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 422.1 II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1965 to July 1 1968 , that (I) (we) last saw the deceased alive on July 1 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Dr. Brumgardner				23B. DATE SIGNED 7/3/68	
23C. PHYSICIAN'S NAME (Type) Dr. Brumgardner				23D. ADDRESS Balto 21237	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/68		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens	
				24D. LOCATION (City, town, or county) (State) Belair, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Grudzinski Funeral Home	
				ADDRESS 1407 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6979	
D-100 68- 6979 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Florence F DeBow		2. DATE AND HOUR OF DEATH July 5 '1968 1:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen'l Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1345 Weldon Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward L. Hovermale			14. MOTHER'S MAIDEN NAME Clara Virginia Michael		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Margaret F Whitmore
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease 10+ yrs.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF disease (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 420.1 II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug. 15 19 63 to July 19 68 , that (I) (we) last saw the deceased alive on June 22 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. J. Liu M.D.				23B. DATE SIGNED July 5 '1968	
23C. PHYSICIAN'S NAME (Type) S. J. Liu M.D.				23D. ADDRESS 5301 Harford Road Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-68		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem	
24D. LOCATION Baltimore Co Md		24E. DATE REC'D BY HEALTH DEPT. JUL 8 1968		24F. NAME OF REGISTRAR Paul E. Talbot	
24G. FUNERAL DIRECTOR Burgee Funeral Home		24H. ADDRESS Baltimore Md		24I. BY WHOM By Notary	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 68- 6980			
1. NAME OF DECEASED (Type or Print) J. Triplett Haxall Jr.		2. DATE AND HOUR OF DEATH 7/7/68 355 A M	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Cnty C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1816 E 36th St.	
5. SEX Male	6. RACE Caucasian	7. NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-98
9. AGE (In years lost birthday) 70		10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROOKER		10B. KIND OF BUSINESS OR INDUSTRY STOCK	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Triplett Haxall	
14. MOTHER'S MAIDEN NAME Rose S. Gordon		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI U.S.N.	
16. SOCIAL SECURITY NO. 214-03-5043		17. INFORMANT JOHN D. HAXALL 821 ORIO AVE LEMOYNE PA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ruptured aortic abdominal aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. abdominal aneurysm		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 451X II none		(C) DUE TO, OR AS A CONSEQUENCE OF:	
19A. DATE OF OPERATION 3 7/7/68	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal rupture of aneurysm	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 68 to 7/7 19 68 , that (I) (we) lost saw the deceased alive on 7/7 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Vincent F. Reale MD		23B. DATE SIGNED 7/7/68	
23C. PHYSICIAN'S NAME (Type) VINCENT F. REALE		23D. ADDRESS 1620 McElderry St. #1044, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION	24B. DATE 7-8-1968	24C. NAME OF CEMETERY or CREMATORY GREENMONT	24D. LOCATION (City, town, or county) (State) BALTO MD
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968	25B. NAME OF REGISTRAR Robert E. Johnson	25C. FUNERAL DIRECTOR HENRY W. JENKINS & SONS CO. ADDRESS 4905 YORK RD	

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Vincennes, Ind.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-352 68-6981				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6981	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARIE H. BOETTINGER		2. DATE AND HOUR OF DEATH 7/6/68 1155 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 626 MELVILLE AVE			
5. SEX F	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN J. HARTMAN				14. MOTHER'S MAIDEN NAME MARY HUBBELL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-36-8489		17. INFORMANT MRS. REGINA FLUHARTY		ADDRESS 2434 PICKWICK RD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 156.1 ARCINOMA COMMON BILE DUCT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/20/68 19 to 7/6 19 68 , that (I) (we) last saw the deceased alive on 7/6 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Martin E. Zipser M.D.				23B. DATE SIGNED 7/6/68			
23C. PHYSICIAN'S NAME (Type) Dr. Martin E. Zipser				23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/68		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Tabor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto. 12, Md.	

1884-1885

James K. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6982
BIRTH NO.		68- 6982		H-235	
1. NAME OF DECEASED (Type or Print)			Kenneth M. Huston		
2. DATE AND HOUR OF DEATH			July 7, 1968		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
00 3208 Tyndale Ave.			C. CITY OR TOWN Baltimore 21214		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3208 Tyndale Ave.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired-Engineer		Chemical		Indiana	
13. FATHER'S NAME Charles Huston			14. MOTHER'S MAIDEN NAME Flora Davis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 216-01-7143A		
			17. INFORMANT Mrs. Loretta A. Huston		
			ADDRESS (Same)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (C) ... APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 5 to 7 July 1968, and that (I) last saw the deceased alive on 7 July 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles H. Reier M.D.				23B. DATE SIGNED 8 July 68	
23C. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier				23D. ADDRESS 6701 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7/10/68		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 8 1968		Robert E. Jenkins		H.W. Jenkins & Sons Co. 4905 York Rd. Bal to 12, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				68- 6983		68- 6983	
K-241				REG. NO.			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
KISSELEBURG MRS VIRGINIA				7-5-1968		2-10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35				E. STREET AND NUMBER 3032 st Paul st			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		3-19-19	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
49		ANTIQUE DEALER		MD.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
RALPH F BERGMAN				ALMA FOWLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				220-09-6729		MRS. MERCER McCOMAS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
171X I				Ca of Cervix			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
171X II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (N) (this hospital) attended the deceased from 6-20-1968 to 7-5-1968, that (N) (we) lost saw the deceased alive on 7-5-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
VENERATION						7/5/68	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
VENERATION						CHH	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-8-68		Lorraine Park		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1968		A. C. G. E. J. J. J. J.		H. W. Jenkins & Sons Co.		4905 York Rd. Balto., Md.	

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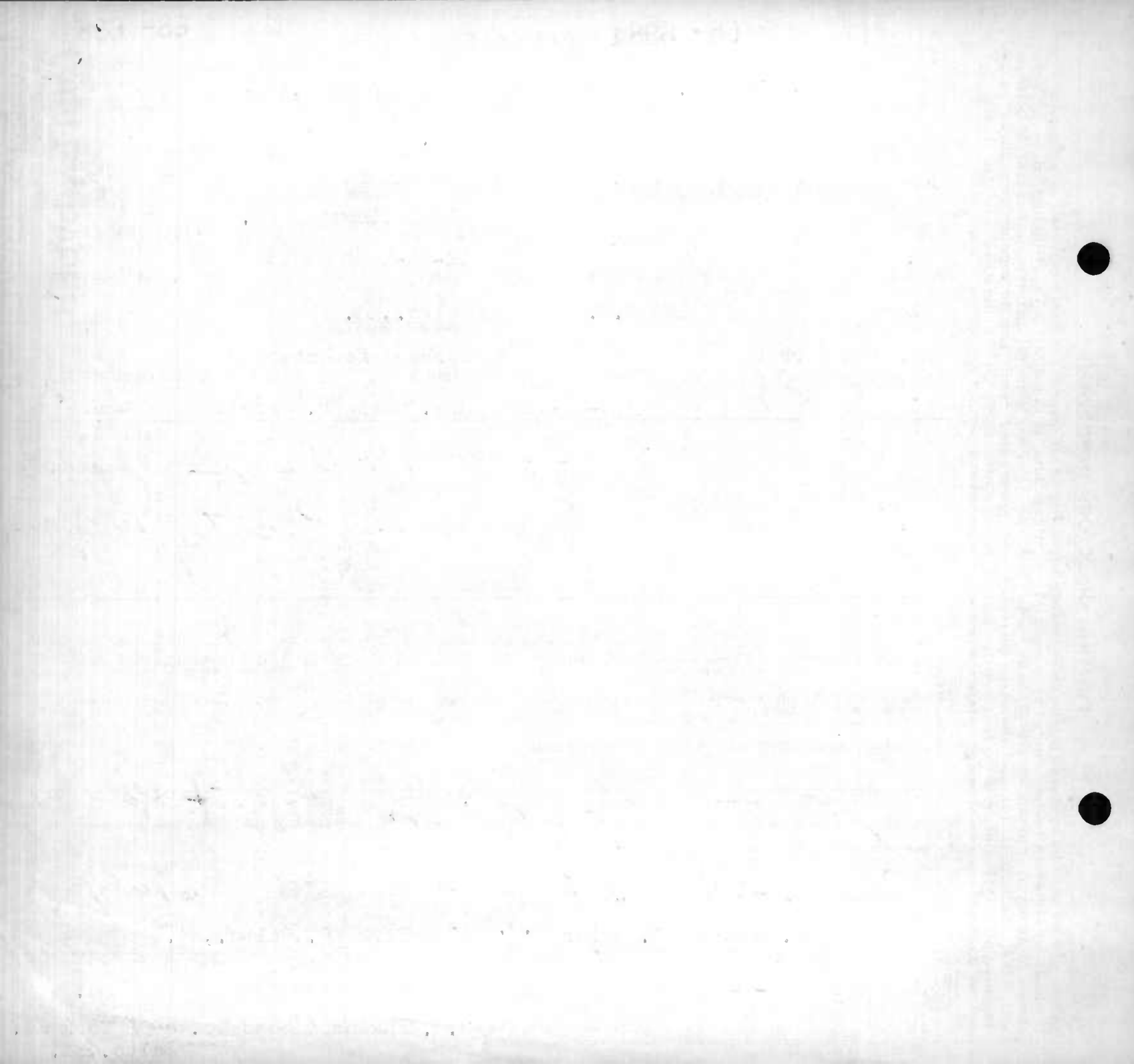
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

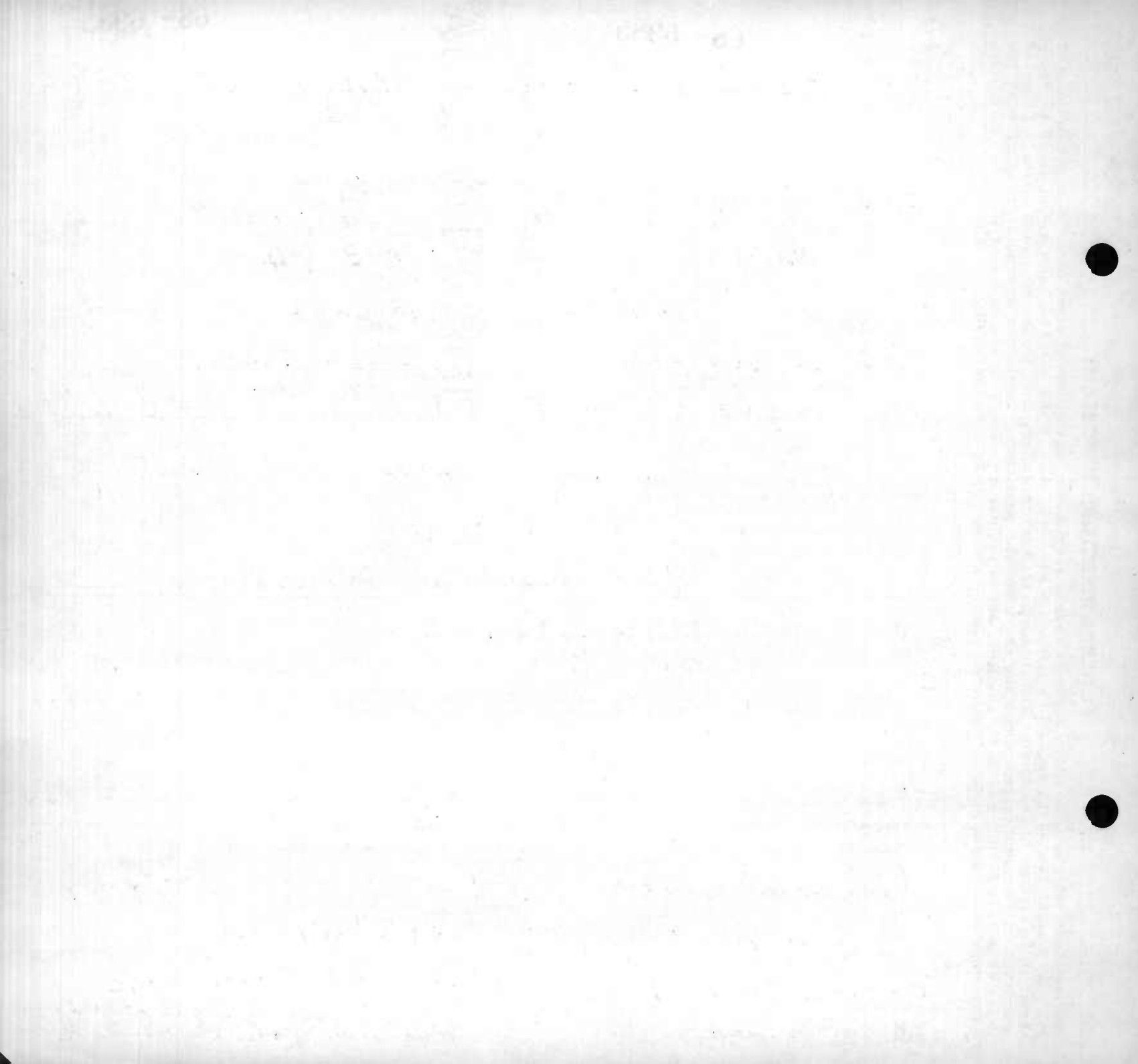
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6984	
G-630 68- 6984 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WILLIAM M. GARRETT			2. DATE AND HOUR OF DEATH July 5, 1968 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1651 Kingsway Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1651 Kingsway Rd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-1888	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Garrett			14. MOTHER'S MAIDEN NAME Barbara Rosenberger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-7054		17. INFORMANT Mrs. Marie M. Garrett	
				ADDRESS Same	
18. 185X I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Cornary Occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Prostate (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 10 years					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 177X II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1946 to 5 July 1968 , that (I) (we) last saw the deceased alive on 5 July 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles H. Reier M.D.			23B. DATE SIGNED 6 July 1968		
23C. PHYSICIAN'S NAME (Type) Dr. Charles H. Reier M.D.			23D. ADDRESS 6701 York Rd., Balto., Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 7-8-68		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial	
24D. LOCATION Timonium		24E. (City, town, or county) Md.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1968		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Rd. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6985
5-240		68-6985		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) NELLIE SACKEL		2. DATE AND HOUR OF DEATH July 8, 1968 8:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) 52 S. Fullen Ave. Baltimore, Md.		
FULL NAME OF HOSPITAL OR INSTITUTION 2327 N. Charles St. Baltimore, Md. - 21218		C. CITY OR TOWN Baltimore, Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 26, 1883	9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Vinyard		
14. MOTHER'S MAIDEN NAME Ida Ross		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE		
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Russell Harris		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarct		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:		
(C) Generalized Arteriosclerosis				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 420.1 II - Cataracts -				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 12-4-1966 to 7-8-1968 , that (I) (we) lost saw the deceased alive on 7-8-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Cesar Valle Cervero M.D.		23B. DATE SIGNED 7-8-68		23C. PHYSICIAN'S NAME (Type) CESAR VALLE CERVERO M.D.
23D. ADDRESS 8629 Liberty Rd.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 7-11-68		24C. NAME OF CEMETERY or CREMATORY London Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home



FUNERAL DIRECTOR: IMPORTANT

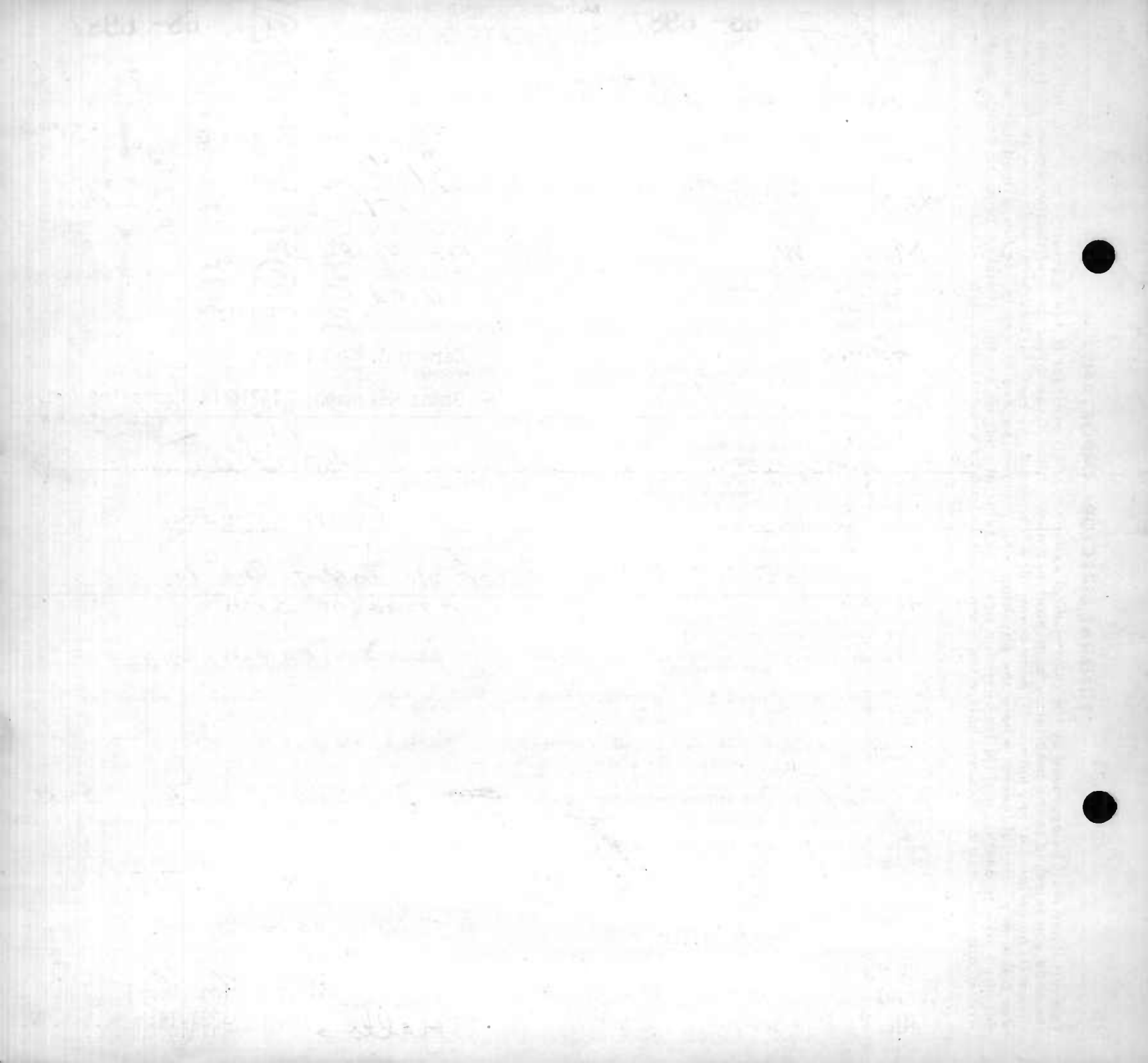
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-436 68-6986				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6986	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELDERKIN, LYDIA Alice				2. DATE AND HOUR OF DEATH 7/8/68 8:50A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 STAGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN ATOWNSVILLE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 98 SMITHWOOD AVENUE (SUMMIT NURSING HOME)			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 3 86	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME RICHARD FANTOM				14. MOTHER'S MAIDEN NAME ANNA MARTIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT ST AGNES HOSPITAL RECORDS CATON BALTO MD 21229		ADDRESS WILKENS &	
18. 560.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Intestinal Obstruction DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19. 570.5 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/7/68 to 7/8/68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/8/68 and that in <input checked="" type="checkbox"/> (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXXX) view the body after death.							
23A. SIGNATURE James G. Kane, M.D.				23B. DATE SIGNED 7.8.68		23C. PHYSICIAN'S NAME (Type) JAMES G KANE, M.D.	
23D. ADDRESS ST AGNES HOSPITAL-BALTO MD 21229				23E. FUNERAL DIRECTOR Francis H. Miller 2101 Frederick Ave.			
24A. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		24B. DATE 7-10-68		24C. NAME of CEMETERY or CREMATORY London Park		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Fisher		25C. ADDRESS 6501 L. Schumaker Hwy, Baltimore, Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

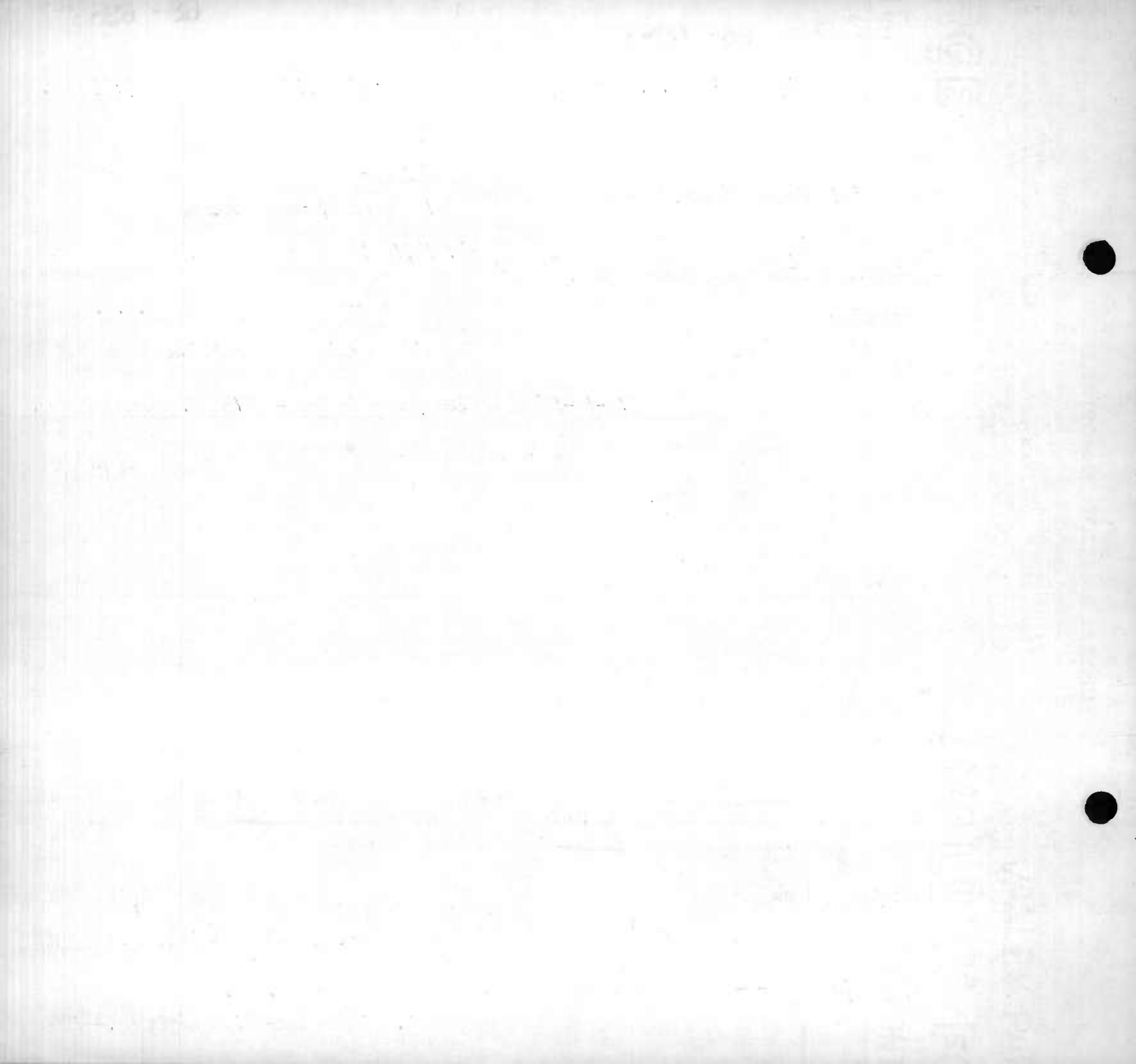
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6987	
<div style="display: flex; justify-content: space-between;"> M-452 68-6987 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <i>Henry Melenson</i>		2. DATE AND HOUR OF DEATH <i>7/3/68 8:30 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Montgomery Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital of Baltimore Inc.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Silver Spring</i> D. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				E. STREET AND NUMBER <i>14786 New Hampshire Ave.</i>	
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 19, 68</i>		9. AGE (In years lost birthday) <i>4 months</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>U.S.A. MARYLAND</i>	
13. FATHER'S NAME <i>James</i>			14. MOTHER'S MAIDEN NAME <i>Carman A. Cummings</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>James Melenson 14716 N. Hampshire Ave.</i>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Aspiration</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Severe Brain Injury</i></p> <p>(C) <i>Decorticate Infant 2nd to Apnea at Birth</i></p> </div> </div>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>760.0 II</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>July 2, 1968</i> to <i>July 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>4 PM - 7/3 - 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J Meyer Heller MD</i>				23B. DATE SIGNED <i>7/3/1968</i>	
23C. PHYSICIAN'S NAME (Type) <i>Meyer Heller</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-8-68</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gate of Heaven</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. LOCATION (City, town, or county) <i>Silver Spring</i>		24F. LOCATION (State) <i>Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>J Heller</i>	
ADDRESS <i>3821 14th St. Washington, D. C. N. W.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6988	
BIRTH NO. H-320		68-6988		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Hedwig (Hattie) M.A. Roos</i>			2. DATE AND HOUR OF DEATH <i>July 4, 1968</i> 3:55 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>60 3815 Mount Pleasant Avenue</i>			A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>3815 Mount Pleasant Avenue</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 14, 1881</i>	9. AGE (In years last birthday) <i>87</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wilhelm Ahlfeldt</i>		14. MOTHER'S MAIDEN NAME <i>Wilhelmina Krumbien</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-10-1248</i>		17. INFORMANT <i>Miss Jeanette Roos- 3815 Mt. Pleasant Ave.</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Arteriosclerosis CVD</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10yrs</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>422.1 II</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4 Sep 1953</i> to <i>4 July 1968</i> , that (I) (we) last saw the deceased alive on <i>2 July 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death.					
23A. SIGNATURE <i>Howard Erdmann</i>				23B. DATE SIGNED <i>5 July 68</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>8604 Harford Rd Balto (34) Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>7-8-68</i>		24C. NAME of CEMETERY or CREMATORY <i>Greenmount Crematory</i>	
24D. LOCATION (City, town, or county) <i>Balto. Md.</i>		24E. ADDRESS (State) <i>Balto. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1968</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Rd.-21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-620		68- 6989		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6989	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		M.	
		Frese, Paul H.		7-4-68 6 A/M			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Maryland				Maryland Baltimore Co 53-00			
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				325 Magnolia Terrace 21221			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tool shop worker Ret-Airpax						GERMANY	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Herman Frese				Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
UNKNOWN				214-01-7922-Records: BCH-4940 Eastern Avenue 21224		ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Cardiac arrest			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction			
ANTECEDENT CAUSES				(B) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic heart disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				9 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 6-24 19 68 to 7-4 19 68, that (I) (we) last saw the deceased alive on 7-4-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lee J. Cordova M.D.				7-4-68			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Lee J. Cordova M.D.				4940 Eastern Ave, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/8/68		Oak-Lawn Cem.		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 9 1968		Robert E. Fisher		J. B. Connelly Sons Esq. Md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6990
M-552		68-6990		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charles Joseph Meningers		
2. DATE AND HOUR OF DEATH 7-4-68 4:50 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) 6. STATE Ind 8. COUNTY Baltimore		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel (K-H)		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME John Meninger		14. MOTHER'S MAIDEN NAME Rose Rosenberger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-5303		17. INFORMANT Wife
18. 432.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hr.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis		
(B) DUE TO, OR AS A CONSEQUENCE OF: ?		(C) DUE TO, OR AS A CONSEQUENCE OF:		
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 332X II				
19A. DATE OF OPERATION July 1. 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Stenosis of rt. int. carotid art.		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 30 19 68 to July 3 19 68 , that (I) (we) last saw the deceased alive on July 3 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Hung-jen Fu M.D.				23B. DATE SIGNED 7/4/68
23C. PHYSICIAN'S NAME (Type) DR. Hung-jen Fu. M.D.		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/68		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR J. J. Connolly Sons		
25D. ADDRESS Essex Md.				

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	68- 6991 4
5-620		68- 6991		CERTIFICATE OF DEATH	
BIRTH NO. 68-12251		1. NAME OF DECEASED (Type or Print) BABY BOY SAYERS			
2. DATE AND HOUR OF DEATH JULY 4 1968 5:20 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN Hosp. of Md. 730 Ashburton St Baltimore 12, Md		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 12 Stabilizer Dr.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4 1968	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hour: Min: 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME EARL F. JR. SAYERS		14. MOTHER'S MAIDEN NAME Pheresa Cannon	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Parents ADDRESS Same	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Prumaturity DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 776X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 4 1968 to same date 19 68 , that (I) (we) last saw the deceased alive on JULY 4 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Vilma F. Tadalan MD		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) VILMA F. TADALAN	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Removal			
24B. DATE 7/5/68		24C. NAME OF CEMETERY or CREMATORY Tazewell Cemetery		24D. LOCATION (City, town, or county) (State) Tazewell Va	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Feltman		25C. FUNERAL DIRECTOR J. J. Connelley Sons - Esq Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-5358 68-6992				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6992	
1. NAME OF DECEASED (Type or Print) <u>Smith, Samuel H.</u>				2. DATE AND HOUR OF DEATH <u>7/4/68</u> <u>125</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltes Co</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48</u>				C. CITY OR TOWN <u>Essex (21)</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>1808 Elk. Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 10-1905</u>		9. AGE (In years birth day) <u>62</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Estimator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hughes Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>James T. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Drouney</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wife</u>	
18. <u>441.2 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory distress</u> <u>Ruptured Abdominal Aneurysms</u> (B) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>24 hrs</u> <u>730 yrs</u>	
MEDICAL CERTIFICATION <u>451X II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-4-1968</u> to <u>7-4-1968</u> , that (I) (we) lost saw the deceased alive on <u>7-4-68</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Mohammad Sid</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7/4/68</u>	
23C. PHYSICIAN'S NAME (Type) <u>MOHAMMAD SID</u>				23D. ADDRESS			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/68</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Mem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1968</u>		25B. NAME OF REGISTRAR <u>Robert E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Connolly Funeral Home</u>		ADDRESS <u>300 Maca</u>	

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68- 6993

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68- 6993

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM C. RUPPERT Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> July 5, 1968 9:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 5, 1968 9:20 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Mar-22-1915 53		E. STREET AND NUMBER 28 Riverside Road, Eastern Terrace	
11. BIRTHPLACE (State or foreign country) Maryland		13. FATHER'S NAME Charles Ruppert	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		15. MOTHER'S MAIDEN NAME Grace Andree	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 913-07-2163	
18. INFORMANT Wife		ADDRESS Same	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) No	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/6/68		DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/68	
24C. NAME OF CEMETERY or CREMATORY Oak-Lawn		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR J. G. Connelly Sons - Essex Md.		ADDRESS	

05-1233

05-1233

WALL LEX 1000000

VALLEY 1000000

200/1000000

T-526

68-6994

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

68-6994

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY TANKERSLEY				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 3, 1968 Hour 2:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospital				3. DATE PRONOUNCED DEAD Month Day Year July 3, 1968 Hour 2:45 P.M.	
6. SEX Male		7. RACE White		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Essex D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 314 Poplar Road			
9. DATE OF BIRTH Nov 18-1918		10. AGE (In years lost birthday) 49		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME HARRY SR.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETH-STEEL		15. MOTHER'S MAIDEN NAME FRANZ			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service)		17. SOCIAL SECURITY NO. 219-03-7237		18. INFORMANT WIFE	
19. 412.4		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		21. AUTOPSY? (Yes or No) Yes	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 4, 1968	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/68		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR J. G. Connelley Sons - Essex Md.		ADDRESS Essex Md.			

NOV-18-1918 4P
MARYLAND

BOTH-STEEL FRANKS
JANES

Charles F. [Signature]

WALLING

FUNERAL DIRECTOR: IMPORTANT

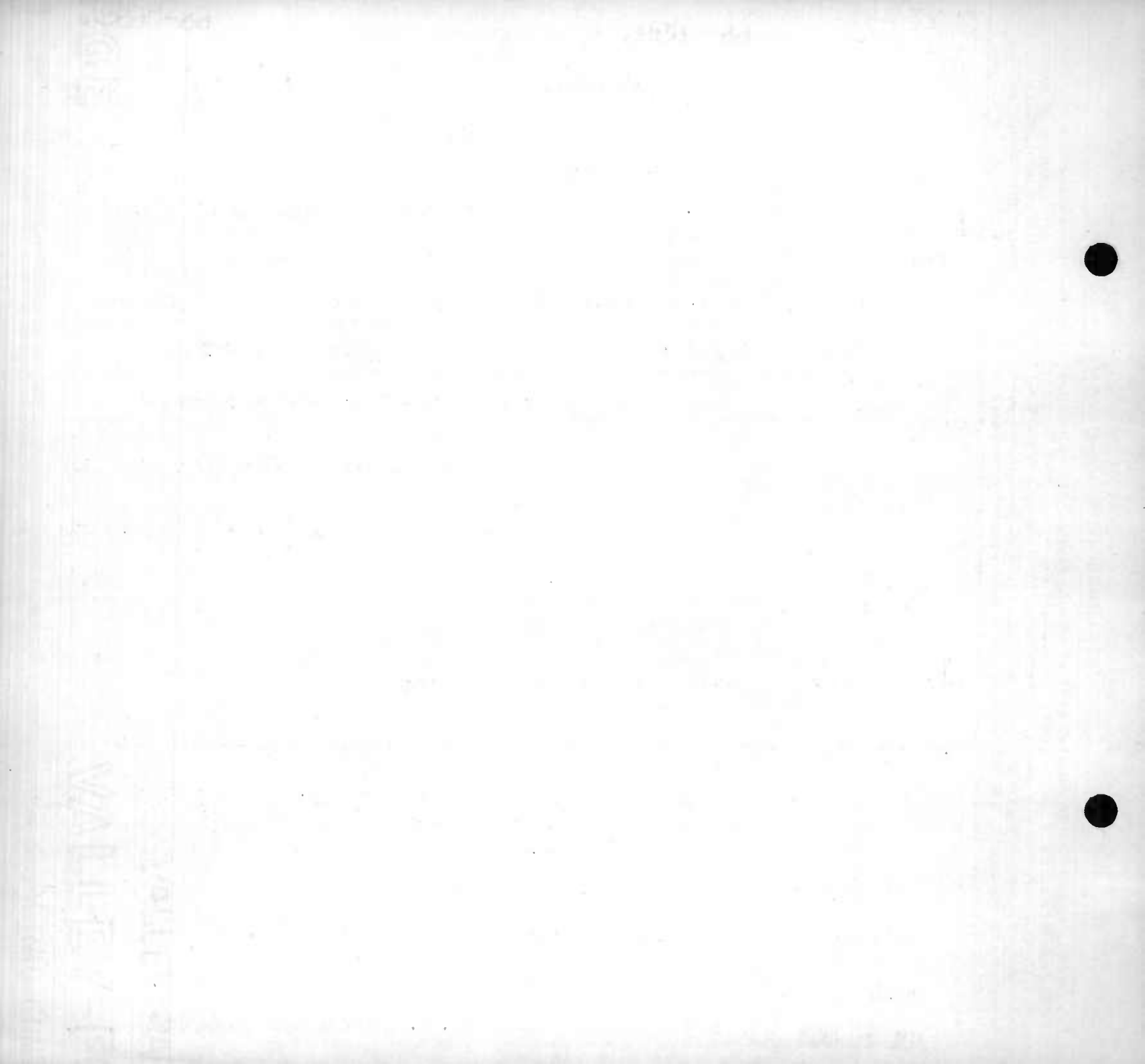
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68- 6995	
1. NAME OF DECEASED (Type or Print) ALBERT E. DIX			2. DATE AND HOUR OF DEATH 4 JUL 68 11:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED 7/12/68 Mercy Hospt. Baltimore Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4503 Post Rd.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 1899 March 1889	9. AGE (In years last birthday) 70 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Off.		10B. KIND OF BUSINESS OR INDUSTRY City Police		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Dix		14. MOTHER'S MAIDEN NAME Dora Stieffler	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 219-40-5971		17. INFORMANT ADDRESS Mrs. Freida M. Dix 4503 Post Rd. Balto. 15	
18. 250.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE ARTEROSCLEROTIC DUE TO, OR AS A CONSEQUENCE OF: CARDIOVASCULAR DISEASE with MARKED congestive heart failure (B) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 260X II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 14 JUN 1968 to 4 JUL 1968 , that we (we) last saw the deceased alive on 4 JUL 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Salvatore R. Donohue MD				23B. DATE SIGNED 4 JUL 68	
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE MD				23D. ADDRESS MERCY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/68		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Loring Byers Chapel 8728 Liberty Rd. Randallstown Md. 21133			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68- 6996	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>JOHNS R. HOPKINS</i>		2. DATE AND HOUR OF DEATH <i>July 5 1968 10.06 A M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Maryland General Hospital 48</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>OWINGS MILLS</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>10808 Reisterstown Road.</i>			
5. SEX <i>MALE</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <i>3/28/05</i>	9. AGE (In years last birthday) <i>63</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARM Supplies</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>GENERAL Farm Store</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> 12. CITIZEN OF WHAT COUNTRY? <i>AMERICA</i>	
13. FATHER'S NAME <i>JOHNS HOPKINS</i>			14. MOTHER'S MAIDEN NAME <i>Ida Butler.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>UNKNOWN</i>		16. SOCIAL SECURITY NO. <i>216-03-5968</i>		17. INFORMANT <i>CHART & Aunt Mrs. TALKMAN</i> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CARCINOMATOSIS, INANITION.</i> (B) <i>SPLENIC FLEXURE CARCINOMA</i> (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> <i>9 months</i>	
19A. DATE OF OPERATION <i>FALL 1967.</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CARCINOMA COLON</i>		20A. AUTOPSY? (Yes or No) <i>NO</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>OCT 1967</i> to <i>July 5 1968.</i> that (I) (we) last saw the deceased alive on <i>July 4 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Michael K. Finegan M.D.</i>				23B. DATE SIGNED <i>July 5 1968.</i>	
23C. PHYSICIAN'S NAME (Type) <i>MICHAEL K. FINEGAN M.D.</i>				23D. ADDRESS <i>111, W. MONUMENT Street 21201</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/8/68</i>		24C. NAME of CEMETERY or CREMATORY <i>St Thomas Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Owings Mills, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1968</i> 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> 25C. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i> ADDRESS <i>Reisterstown, Md.</i>			



1

D-153 68-6997 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 68-6997

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLIFTON DIEFENDERFER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> July 2, 1968 Hour 7:34 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1968 7:34 A.M.	
6. SEX male	7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Feb. 23, 1909		10. AGE (In years last birthday) 59 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 214-05-6103	
18. INFORMANT Mrs. Florence Jopp-Denton, Maryland (Sister)		ADDRESS	
19. CAUSE OF DEATH Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 5	
24C. NAME OF CEMETERY or CREMATORY Stevensville		24D. LOCATION (City, town, or county) (State) Stevensville Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert P. Farley, M.D.	
25C. FUNERAL DIRECTOR Edgar L. Lane - Church Hill, Ind.		ADDRESS	

VS 151-REV. 1/1/68

18-00000

18-00000

WALSH & POLK

PROVIDENCE CAPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-6998	
<div style="display: flex; justify-content: space-between;"> R-300 68-6998 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) GLADYS REED		2. DATE AND HOUR OF DEATH 7-4-68 6:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND 8. COUNTY KENT 6437			
FULL NAME OF HOSPITAL OR INSTITUTION CITYRCH HOME & HOSPITAL 35		C. CITY OR TOWN CITESTERTOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> ? NO <input type="checkbox"/>	
FULL ADDRESS OR LOCATION 204 CAMPUS AVE.		E. STREET AND NUMBER			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-7-1910	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH EVERETT		14. MOTHER'S MAIDEN NAME JOANNA BLACKSTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-14-3005		17. INFORMANT ADDRESS H.J. Reed - GRASONVILLE MD.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) INTESTINAL CARCINOMATOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. BRERST CA. (L)		CAUSE OF DEATH INTRESTIAL CARCINOMATOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRERST CA. (L) (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 Yrs	
170X II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-28-68 19 to 7-4-68 19, that (I) (we) last saw the deceased alive on 7-4-68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE Ricardo M. Tarsen M.D.		23B. DATE SIGNED 7-4-68		23C. PHYSICIAN'S NAME (Type) Ricardo M. Tarsen M.D.	
23D. ADDRESS CITYRCH HOME & HOSPITAL		24. NAME OF CEMETERY or CREMATORY WOODLAWN MEMORIAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 6		24C. LOCATION (City, town, or county) (State) EASTON TALBOT MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Edgar L. Lane Church Hill, Md.	

Chief Clerk
✓ 2-11-28

W
M
Joseph Everett
Journal Blackman

INTERIOR CATHEDRAL

BRITISH CA (L)

N.A.

✓ 2-11-28

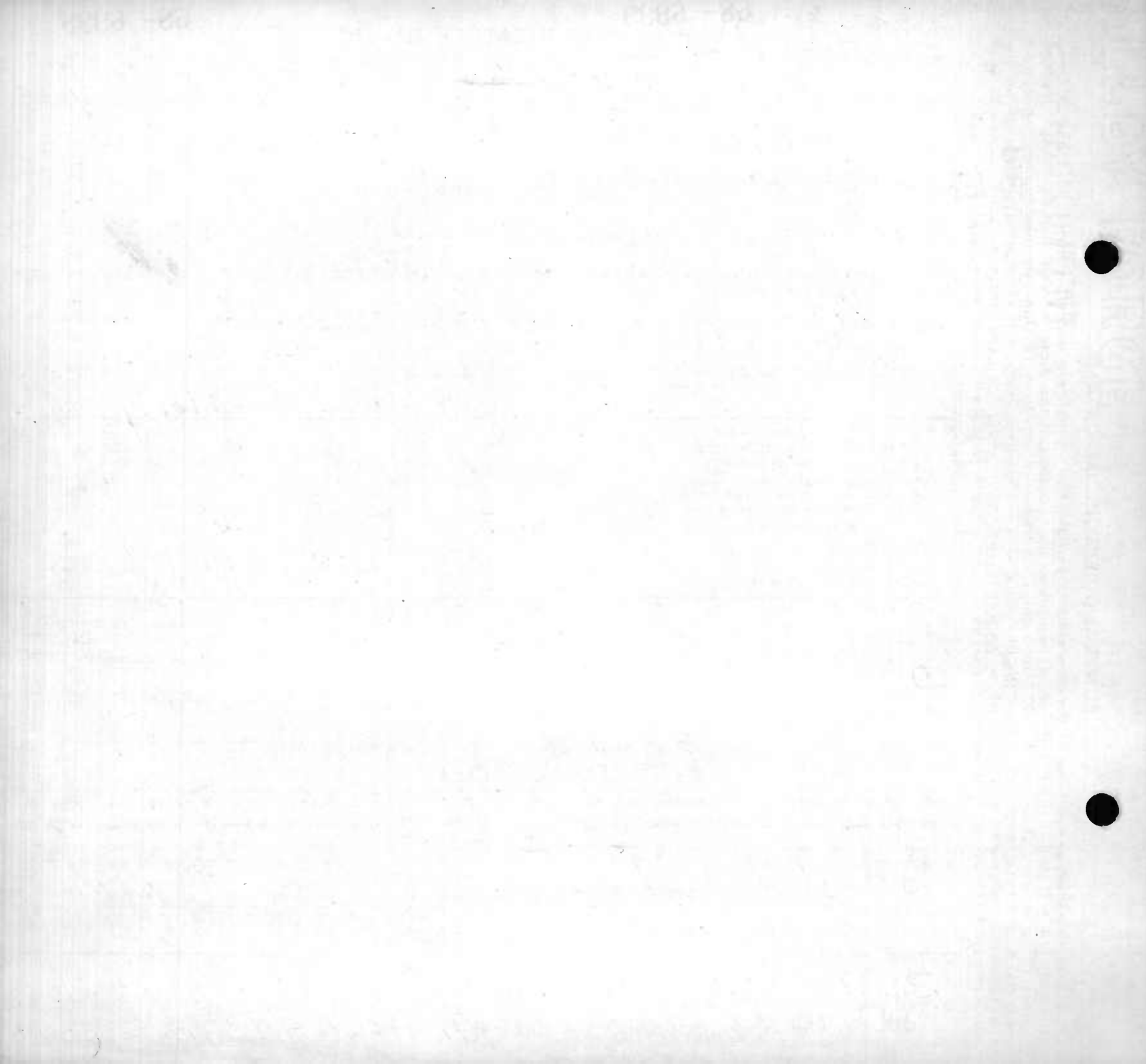
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✓ 2-11-28
Rando M. T. Mason M.D. Chief Clerk & Clerk

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-364 68-12019-6999		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 68-6999	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Howard Otrs Shetterly, Baby Boy		2. DATE AND HOUR OF DEATH 12:55 P.M. 7/7/68	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 2962 Mallview Ave.			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balt., Md.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER Above.	
5. SEX M	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-68	9. AGE (In years last birthday) 6	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Shetterly, William		14. MOTHER'S MAIDEN NAME Sean L. Coran	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Wm. E. Shetterly Mallview	
18. 743.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: multiple Congenital Anomalies - Bilat. Club feet (B) DUE TO, OR AS A CONSEQUENCE OF: Bilat Cryptorchidism (C) DUE TO, OR AS A CONSEQUENCE OF: Microphallus Hypoglycemia			
19. DATE OF OPERATION 75-3.1 II		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/1/68 to 7/7/68, that (1) (two) last saw the deceased alive on 7/7/68 and that in (my) (their) opinion death occurred on the date and hour and from the causes stated above, (1) (two) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph H. Richman M.D.		23B. DATE SIGNED 7/7/68		23C. PHYSICIAN'S NAME (Type) Joseph H. Richman	
23D. ADDRESS Sinai Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/9/68		24C. NAME OF CEMETERY or CREMATORY Meadowridge		24D. LOCATION (City, town, or county) (State) Porsey-Howard Bldg.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR McCauley, H. 237 Patapsco Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
C-621 68-7000					CERTIFICATE OF DEATH					
BIRTH NO.					REG. NO. 68-7000					
1. NAME OF DECEASED (Type or Print) ELMER E. CRISPENS					2. DATE AND HOUR OF DEATH 7/8/68 4:40 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSPITAL 48					A. STATE MD.		B. COUNTY ANNES Arundel			
					C. CITY OR TOWN BROOKLYN		D. INSIDE CITY LIMITS? NO			
E. STREET AND NUMBER 312 ORCHARD AVE. 21225										
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/1890	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN			10B. KIND OF BUSINESS OR INDUSTRY MANUFACTURE OF BRICKS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LOUIS CRISPENS					14. MOTHER'S MAIDEN NAME MARY FOSTER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>			16. SOCIAL SECURITY NO. 215-05-7747		17. INFORMANT LOUETTE CRISPENS			ADDRESS 312 ORCHARD AVE. BALTIMORE, MD.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 572.1 II ACUTE MYOCARDIAL INFARCTION TERMINAL BROWND PNEUMONIA GASTROINTESTINAL TRACT HEMORRHAGE 2 wks					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) BLEEDING DIVERTICULI					
					(C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE CA OF THE LARYNX					
19A. DATE OF OPERATION 572.1 II			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 25 1968 to July 8 1968 , that (I) (we) last saw the deceased alive on July 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE E. M. De los Santos Jr. M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 7/8/68		
23C. PHYSICIAN'S NAME (Type) E. M. DE LOS SANTOS JR M.D.					23D. ADDRESS MARYLAND GEN. HOSPITAL 827 LINCOLN AVE, BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/68		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park			24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. A. A. Co.			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1968			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR McCully F.H.			ADDRESS 237 Fatapsco Ave. 21225	

